REPORT OF THE
QUALITY AND PATIENT SAFETY COMMITTEE OF THE
BOARD OF DIRECTORS OF THE
COOK COUNTY HEALTH AND HOSPITALS SYSTEM

JUNE 17, 2009

ATTENDANCE

Present: Acting Chairman Luis Muñoz, MD, MPH and Director Hon. Jerry Butler (2)

Mary Driscoll (Non-Director Member)

Absent: Chairman David Ansell, MD (1)

Also Present: David Barker, MD – Chief Medical Officer, Ruth M. Rothstein CORE Center of Cook County; Angela Butler – Director of Quality Management, Oak Forest Hospital of Cook County; Joanne Dulski – Laboratory Services, Cook County Health and Hospitals System; David Goldberg, MD – President of the Medical Staff, John H. Stroger, Jr. Hospital of Cook County; Aaron Hamb, MD - Chief Medical Officer, Provident Hospital of Cook County; Avery Hart, MD – Interim Chief Medical Officer, Cermak Health Services; Bala Hota, MD – Division of Infectious Disease at John H. Stroger, Jr. Hospital of Cook County; Randall Johnston – Office of the State's Attorney; Sue Klein – Director of Quality, John H. Stroger, Jr. Hospital of Cook County; Maurice Lemon, MD, MPH – Chief Medical Officer, John H. Stroger, Jr. Hospital of Cook County; Charlene Luchsinger – Credentials Verification Officer, Cook County Health and Hospitals System; Enrique Martinez, MD – Chief Medical Officer, Ambulatory and Community Health Network of Cook County; Michael Puisis, MD – Chief Operating Officer, Cermak Health Services; John M. Raba, MD – Interim Chief Medical Officer, Cook County Health and Hospitals System; Deborah Santana – Office of the Secretary to the Board of Commissioners of Cook County; David Small –Chief Operating Officer, Cook County Health and Hospitals System

Ladies and Gentlemen:

Your Quality and Patient Safety Committee of the Board of Directors of the Cook County Health and Hospitals System met pursuant to notice on Wednesday, June 17, 2009 at the hour of 12:00 P.M. at Stroger Hospital, 1901 West Harrison Street, in the fifth floor conference room, in Chicago, Illinois.

Your Quality and Patient Safety Committee has considered the following items and, upon adoption of this report, the recommendations follow.

Roll Call

Deborah Santana, of the Office of the Secretary to the Board, called the roll of members, and it was determined that a quorum was present.

Public Comments

Acting Chairman Muñoz asked the Secretary to call upon the registered speakers.

The Secretary responded that there were none.

Review and accept minutes of the meeting of May 26, 2009

Director Butler, seconded by Acting Chairman Muñoz, moved to accept the minutes of the meeting of the Quality and Patient Safety Committee of May 26, 2009. THE MOTION CARRIED UNANIMOUSLY.

Receive quarterly quality report from Stroger Hospital

Sue Klein, Director of Quality for John H. Stroger, Jr. Hospital of Cook County, and Dr. Maurice Lemon, Chief Medical Officer of John H. Stroger, Jr. Hospital of Cook County, presented the quarterly quality report (Attachment #1).

The Committee reviewed and discussed the information provided.

Director Butler, seconded by Acting Chairman Muñoz, moved to accept the quarterly quality report from Stroger Hospital. THE MOTION CARRIED UNANIMOUSLY.

Receive overview of opportunities to use existing databases to track/monitor/report on clinical information, activities and events

Dr. Bala Hota, of the Division of Infectious Diseases at John H. Stroger, Jr. Hospital of Cook County, presented a report on the opportunities to use existing databases to track, monitor, and report on clinical information, activities and events.

The Committee reviewed and discussed the information. During the discussion, Dr. Hota noted that the System is the only site in Chicago to use BioSense. This is a national program used to conduct bio-surveillance, by sending real-time information to the Centers for Disease Control. Acting Chairman Muñoz requested additional information on the subject.

Director Butler, seconded by Acting Chairman Muñoz, moved to receive and file the information provided by Dr. Hota. THE MOTION CARRIED UNANIMOUSLY.

Receive update on the issue of Smoke-free campuses

David Small, Chief Operating Officer of the Cook County Health and Hospitals System, provided an update on the issue of Smoke-free campuses (Attachment #2).

A committee with representation from the System Affiliates has been formed to chart and oversee the plan to implement a smoke-free policy for all of the System's campuses. They are in the process of developing initial signage and message posting to alert the public and staff of the intent to implement smoke-free environments for all System campuses.

Receive update on Laboratory surveys at Stroger Hospital

Joanne Dulski, Director of Laboratory Services for the Cook County Health and Hospitals System, presented an update on the Laboratory surveys at Stroger Hospital (Attachment #3).

The Committee reviewed and discussed the information provided.

Director Butler, seconded by Acting Chairman Muñoz, moved to accept the report providing an update on the Laboratory surveys at Stroger Hospital. THE MOTION CARRIED UNANIMOUSLY.

Receive report on status of preparations for Cermak re-accreditation

Receive reports from the Medical Staff Executive Committees from Oak Forest, Provident and Stroger Hospitals

Receive and approve Medical Staff Appointments/Re-appointments/Changes

Receive reports on the following:

- **Any Sentinel Events or Near Misses**
- **Any Patient Grievance Reports**
- **Update on "never" events**
- **Report on Recent Regulatory Visits**

Acting Chairman Muñoz, seconded by Director Butler, moved to recess the regular session and convene into closed session, pursuant to an exception to the Illinois Open Meetings Act, 5 ILCS 120/2(c)(17), et seq., which permits closed meetings for consideration of "the recruitment, credentialing, discipline or formal peer review of physicians or other health care professionals for a hospital, or other institution providing medical care, that is operated by the public body," and pursuant to an exception to the Open Meetings Act, 5 ILCS 120/2(c)(11), which states: "litigation, when an action against, affecting or on behalf of the particular body has been filed and is pending before a court or administrative tribunal, or when the public body finds that an action is probable or imminent, in which case the basis for the finding shall be recorded and entered into the minutes of the closed meeting." THE MOTION CARRIED UNANIMOUSLY.

Acting Chairman Muñoz, seconded by Director Butler, moved to adjourn the closed session and convene into regular session. THE MOTION CARRIED UNANIMOUSLY.

Director Butler, seconded by Acting Chairman Muñoz, moved to approve the Medical Staff Appointments/Re-appointments/Changes. THE MOTION CARRIED UNANIMOUSLY.

Following are the Medical Staff Appointments/Re-appointments/Changes that were approved:

JOHN H. STROGER, JR. HOSPITAL OF COOK COUNTY

INITIAL APPOINTMENTS

Physicians:

Asbury, Joseph, M.D.	Medicine/General Medicine	Active Physician
Appointment Effective:	June 17, 2009 through June 16, 2011	

John H. Stroger, Jr. Hospital of Cook County
Initial Appointments-Physicians (cont'd):

Basu, Anupam, MD Appointment Effective:	Radiology/Radiation Oncology June 17, 2009 through June 16, 2011	Active Physician
Brandes, Barry A., DPM Appointment Effective:	Surgery/Orthopaedic June 17, 2009 through April 27, 2011	Affiliate Physician
Coleman, Nathaniel, M.D. Appointment Effective:	Medicine/General/ACHN June 17, 2009 through June 16, 2011	Active Physician
Friedman, Yaakov, M.D. Appointment Effective:	Medicine/Pulmonary/Critical Care June 17, 2009 through June 16, 2011	Affiliate Physician
Hickey, Colleen, M.D. Appointment Effective:	Emerg Med/Adult Emergency Srvcs June 17, 2009 through June 16, 2011	Active Physician
Kuznetsova, Marina, M.D. Appointment Effective:	Radiology/Radiation Oncology June 17, 2009 through June 16, 2011	Consulting Physician
Mahmarian, Robert R., DPM Appointment Effective:	Surgery/Orthopaedic June 17, 2009 through April 27, 2011	Affiliate Physician
Mennella, Concetta C., MD Appointment Effective:	Correctional Health/Med. Surg. June 17, 2009 through June 16, 2011	Active Physician
Miloro, Michael, DMD, MD Appointment Effective:	Surgery/Oral & Maxillofacial June 17, 2009 through June 16, 2011	Voluntary Physician/ Dentist
Rao, Vamshi, M.D. Appointment Effective:	Correctional Health/Med/Peds June 17, 2009 through June 16, 2011	Voluntary Physician
Simpkins, Janita, M.D. Appointment Effective:	Correctional Health/Med/Fam June 17, 2009 through June 16, 2011	Active Physician
Soyemi, Kenneth, M.D. Appointment Effective:	Pediatrics June 17, 2009 through June 16, 2011	Voluntary Physician
Thakrar, Harishchandra, M.D. Appointment Effective:	Radiology/Radiation Oncology June 17, 2009 through June 16, 2011	Consulting Physician
Verma, Anupam, MD Appointment Effective:	Medicine/Pulmonary CC June 17, 2009 through October 16, 2011	Affiliate Physician

REAPPOINTMENT APPLICATIONS

Physicians:

Department of Anesthesiology

Tyler, Serge, MD Reappointment Effective:	Anesthesiology July 9, 2009 through July 8, 2011	Active Physician

John H. Stroger, Jr. Hospital of Cook County
Reappointment Applications-Physicians

Department of Anesthesiology (cont'd):

Voronov, Gennadiy, MD	Anesthesiology	Active Physician
Reappointment Effective:	June 30, 2009 through June 29, 2011	
Waxler, Beverly, MD	Anesthesiology	Voluntary Physician
Reappointment Effective:	July 9, 2009 through July 8, 2011	

Department of Medicine

Ahmed, Azazuddin A., MD	Nephrology/Hypertension	Active Physician
Reappointment Effective:	June 17, 2009 through June 16, 2011	
Rudziewicz, David T., DDS	Medicine/Dentistry/CORE	Voluntary Dentist
Reappointment Effective:	June 18, 2009 through June 17, 2011	
Telfer, Margaret C., MD	Hematology/Oncology	Active Physician
Reappointment Effective:	June 30, 2009 through May 15, 2010	

Department of Pediatrics

Sisung, Charles, MD	Peds Medicine	Voluntary Physician
Reappointment Effective:	September 15, 2009 through September 14, 2011	

Mid Level Practitioner Reappointments:

Allen, Sharon L., CNP	Medicine	Nurse Practitioner
Reappointment Effective:	July 10, 2009 through July 09, 2011	
Connolly, Colette B., CNS	Correctional Health Services	Clinical Nurse Specialist
Reappointment Effective:	July 10, 2009 through July 09, 2011	
Duda, Jane E., CRNA	Anesthesiology	Nurse Anesthetists
Reappointment Effective:	October 16, 2009 through October 15, 2011	
Duff, Jennifer M., CNP	Pediatrics	Nurse Practitioner
Reappointment Effective:	September 18, 2009 through September 17, 2011	
Marino, Keith A., CRNA	Anesthesiology	Nurse Anesthetist
Reappointment Effective:	September 18, 2009 through September 17, 2011	
Sanchez, Alejandro G., PA-C	Medicine	Physician Assistant
Reappointment Effective:	September 18, 2009 through September 17, 2011	
Sit, Phyllis M., CRNA	Anesthesiology	Nurse Anesthetists
Reappointment Effective:	October 16, 2009 through October 15, 2011	

John H. Stroger, Jr. Hospital of Cook County (cont'd)

Collaborative Agreement		
Connolly, Colette B., CNS	Correctional Health Services	Clinical Nurse Specialist
Collaborative Agreement with Prescriptive Authority		
Allen, Sharon L., CNP	Medicine	Nurse Practitioner
Duff, Jennifer M., CNP	Pediatrics	Nurse Practitioner
Force, Katherine A., PA-C With Dr. Schmidt	Medicine	Physician Assistant
Sanchez, Alejandro G., PA-C	Medicine	Physician Assistant
Change in Privileges		
Force, Katherine A., PA-C With Dr. Rezai	Medicine	Physician Assistant

PROVIDENT HOSPITAL OF COOK COUNTY

INITIAL APPOINTMENTS

Cohen, Robert	Internal Medicine/Pulmonary & Critical Care	Affiliate Physician
Appointment Effective:	June 17, 2009 through June 16, 2011	
Coleman, Nathaniel, M.D.	Internal Medicine//ACHN	Affiliate Physician
Appointment Effective:	June 17, 2009 through June 16, 2011	
Lenhardt, Richard, MD	Internal Medicine/Pulmonary & Critical Care	Affiliate Physician
Appointment Effective:	June 17, 2009 through May 25, 2011	
Patel, Ashlesha, M.D.	OB/Gyn	Affiliate Physician
Appointment Effective:	June 17, 2009 through April 16, 2011	
Swenson, Erik, M.D.	Surgery/General	Affiliate Physician
Appointment Effective:	June 17, 2009 through June 16, 2011	

REAPPOINTMENT APPLICATIONS

Physicians
Department of Anesthesiology

Swiner, Connie, MD	Anesthesiology	Active Physician
Reappointment Effective:	August 8, 2009 through August 7, 2011	

Department of Critical Care

Friedman, Yaakov, MD	Critical Care	Active Physician
Reappointment Effective:	August 1, 2009 through July 31, 2011	

Provident Hospital of Cook County
Reappointment Applications-Physicians (cont'd)

Department of Emergency Medicine

Fleming, Jennifer, MD	Emergency Medicine	Ancillary Physician
Reappointment Effective:	June 17, 2009 through July 21, 2010	

Department of Family Medicine

Cash, Crystal, MD	Family Medicine	Active Physician
Reappointment Effective:	August 1, 2009 through July 31, 2011	
Crawford, Tais MD	Family Medicine	Active Physician
Reappointment Effective:	June 17, 2009 through June 3, 2011	
Daugherty, Milton, MD	Family Medicine	Consulting Physician
Reappointment Effective:	July 31, 2009 through July 30, 2011	
Gibson, Sandy, DO	Family Medicine	Active Physician
Reappointment Effective:	August 1, 2009 through July 31, 2011	
Perry, Isaiah, MD	Family Medicine	Voluntary Physician
Reappointment Effective:	June 17, 2009 through July 16, 2011	

Department of Internal Medicine

Attar, Bashar, MD, Ph.D.	Internal Medicine/Gastroenterology	Affiliate Physician
Reappointment Effective:	July 11, 2009 through December 13, 2010	
Clarke, Clifton, MD	Internal Medicine	Active Physician
Reappointment Effective:	August 1, 2009 through July 31, 2011	
Cohen, Edward, MD	Internal Medicine/Nephrology	Consulting Physician
Reappointment Effective:	August 1, 2009 through July 31, 2011	
Hamb, Aaron, MD	Internal Medicine	Active Physician
Reappointment Effective:	August 1, 2009 through July 31, 2011	
Johnson, Claudia, MD	Internal Medicine/Gastroenterology	Active Physician
Reappointment Effective:	July 30, 2009 through July 29, 2011	
Reynolds, Albert MD	Internal Medicine	Voluntary Physician
Reappointment Effective:	July 11, 2009 through July 10, 2011	
Wright, Lester, MD	Internal Medicine	Active Physician
Reappointment Effective:	June 19, 2009 through June 18, 2011	

Department of Pathology

Ray, Vera, MD	Clinical/Anatomy	Active Physician
Reappointment Effective:	July 31, 2009 through July 30, 2011	

Department of Pediatrics

Yu, Byung-Ho MD	Pediatrics	Affiliate Physician
Reappointment Effective:	August 7, 2009 through June 29, 2011	

Provident Hospital of Cook County (cont'd)

Additional Privileges/Membership

William Clapp, MD Appointment Effective:	Internal Med/Pulmonary June 17, 2009 through March 18, 2011	Affiliate Physician

Change in Status

Gueret, Renaud, MD Critical Care	From Ancillary Physician to Affiliate Physician
Patel, Aiyub, MD Critical Care	From Ancillary Physician to Affiliate Physician
Dardis, Kevin, DO Emergency Medicine	From Active Physician to Voluntary Physician Effective July 31, 2009
Saffold, Carol, MD OB/Gyne	From Active Physician to Ancillary Physician

OAK FOREST HOSPITAL OF COOK COUNTY

INITIAL APPOINTMENTS

Physicians:

Blumetti, Jennifer, M.D. Appointment effective:	Surgery June 17, 2009 through June 16, 2011	Affiliate Physician
Chaudhry, Vivek, M.D. Appointment effective:	Surgery/Colon-Rectal June 17, 2009 through June 16, 2011	Affiliate Physician
Clapp, William D., M.D. Appointment effective:	Medicine/ICU June 17, 2009 through March 18, 2011	Affiliate Physician
Fakhran, Sherene S., M.D. Appointment effective:	Medicine/ICU June 17, 2009 through June 30, 2011	Affiliate Physician
Gueret, Renaud, M.D. Appointment effective:	Medicine/ICU June 17, 2009 through October 16, 2010	Affiliate Physician
Lazzaro, Gianluca, M.D. Appointment effective:	General Surgery June 17, 2009 through April 27, 2011	Affiliate Physician
Mishra, Satya, M.D. Appointment effective:	Surgery/Gastroenterology June 17, 2009 through June 16, 2011	Active Physician
Mwansa, Victor, M.D. Appointment effective:	Medicine/ICU June 17, 2009 through June 16, 2011	Visiting Consultant

Oak Forest Hospital of Cook County
Initial Appointments – Physicians (cont'd)

Patel, Aiyub, M.D.	Medicine/ICU	Affiliate Physician
Appointment effective:	June 17, 2009 through March 196, 2011	
Quesada-Rodriguez, Nancy, M.D.	Medicine/ICU	Affiliate Physician
Appointment effective:	June 17, 2009 through June 16, 2011	
Tulaimat, Aiman, M.D.	Medicine/ICU	Affiliate Physician
Appointment effective:	June 17, 2009 through March 18, 2011	
Verma, Anupam, M.D.	Medicine/ICU	Affiliate Physician
Appointment effective:	June 17, 2009 through October 16, 2010	

MEDICAL STAFF REAPPOINTMENTS

Frigo, Judith B., M.D.	Family Medicine	Active Physician
Reappointment effective:	June 17, 2009 through June 16, 2011	
Lamba, Anil, M.D.	Surgery	Active Physician
Reappointment effective:	June 17, 2009 through June 16, 2011	
Swenson, Erik, M.D.	Surgery	Active Physician
Reappointment effective:	June 17, 2009 through June 16, 2011	

Adjournment

As the agenda was exhausted, Acting Chairman Muñoz declared that THE MEETING WAS ADJOURNED.

Respectfully submitted,
Quality and Patient Safety Committee of the
Board of Directors of the
Cook County Health and Hospitals System

Luis R. Muñoz, MD, MPH, Acting Chairman

Attest:

Matthew B. DeLeon, Secretary

Cook County Health and Hospitals System

Meeting of the Quality and Patient Safety Committee

June 17, 2009

ATTACHMENT #1

JOHN H. STROGER, JR HOSPITAL
QUALITY REPORT
JUNE, 2009

Scope of Services of John H. Stroger, Jr. Hospital of Cook County

John H. Stroger, Jr. Hospital of Cook County is an acute care general teaching hospital whose mission is "To provide a Comprehensive Program of Quality Health Care, with Respect and Dignity, to the residents of Cook County, regardless of their ability to pay."

Patients are accepted for care, treatment, and services based on the ability of the hospital to meet their needs. Patients are not denied access to care for lack of financial resources or insurance coverage.

Many of the hospital's patients have complex medical and social needs; they are an ethnically and culturally diverse group; most have limited financial resources. The scope of services provided by the hospital is commensurate with the needs of the population it serves.

What follows is a summary highlighting the services available at the hospital. More detailed descriptions can be found in departmental scopes of service.

OVERVIEW

The hospital provides inpatient adult and pediatric medical care, surgical services, Level III perinatal services, and critical care services including a Burn Unit. It provides emergency services 24/7, and is a designated Level I Trauma Center. It also provides essential supporting and/or consultative services. The campus also houses a full range of outpatient primary and specialty care clinics.

INPATIENT SERVICES

Medical Services: The Department of Medicine provides general medical services, as well as the following specialty care services: Endocrinology, Renal Diseases, Neurology (including Neurology Procedures), Cardiology (both Invasive and Non-Invasive), Dermatology, Pulmonary Medicine (including Pulmonary Procedures), Gastroenterology (including Gastroenterology Procedures), Infectious Diseases (including Retro-Virology), Rheumatology, Hematology/Oncology, and Allergy. In addition, Medical Critical Care services are available, including both a Cardiac Critical Care Unit and a Medical Critical Care Unit. The hospital also provides on-site dialysis services and infusion therapy services for inpatients and outpatients.

Surgical Services: The following surgical services are available—General Surgery, Vascular Surgery, Cardio-Thoracic Surgery, Breast Oncology, Neuro-Surgery, Ophthalmology, Oral Surgery, Orthopedics, Pediatric Surgery, Plastic Surgery, Urology, Surgical Oncology, Otolaryngology-Head & Neck Surgery, Colon Rectal Surgery, and Surgical Endocrinology. In addition, Surgical Critical Care services are available; the hospital has a Surgical Critical Care Unit and a Neuro-Surgery Critical Care Unit. No organ transplant services are available on-site.

Perinatal Services (Maternity and Neonatal Services): The hospital is a State-designated Level III hospital (for perinatal services) as well as a State-designated Perinatal Center. It provides care to maternity and neonatal patients requiring primary, intermediate, and intensive levels of perinatal care (Levels I, II, and III—the hospital has a Neonatal Intensive Care Unit). As a Perinatal Center, it also provides obstetrical (including maternal-fetal medicine) and neonatal consultation services to its network hospitals, and provides maternal and neonatal transport/transfer services for patients requiring a higher level of care.

Other Obstetrical/Gynecologic Services: The hospital provides primary gynecologic services (medical and surgical, including advanced pelvic and minimally invasive surgery), as well as the specialty services of Reproductive Endocrinology, Gyne-Oncology, and Uro-Gynecology. In addition, voluntary terminations of pregnancy are available at the hospital.

Pediatric Services (in addition to Neonatal Services): General pediatric services are available at the hospital, as well as the following pediatric specialty services: Allergy/Immunology, Cardiology (including non-invasive cardiology procedures plus patent ductus arteriosus [PDA] ligations), Dermatology, Endocrinology, Gastroenterology (including Gastroenterology Procedures), Hematology, Infectious Diseases (including HIV care), Genetics and Metabolism, Oncology, Nephrology, and Neurology. In addition, Pediatric Critical Care services are available. The hospital has a Pediatric Intensive Care Unit.

EMERGENCY, BURN, and TRAUMA SERVICES

The hospital provides emergency services 24/7. Both Adult and Pediatric emergency services are available. Patients requiring monitoring for an extended period of time, yet not requiring inpatient admission, may be cared for in the 23-hour Observation Unit.

The hospital also provides comprehensive Burn Services for adult and pediatric patients who have sustained burn injuries via a variety of mechanisms (flame, scald, chemical, electrocution, frost bite, etc.). The hospital's Burn Unit is one of only 3 in the Chicago area. Once patients have healed from the initial burn injury, reconstructive operative care is provided to facilitate return to as functional a lifestyle as possible. Additionally, the Burn Service provides wound care services for the entire hospital.

As noted in the Overview, the hospital is a State-designated Level I Trauma Center and operates a Trauma Resuscitation Area, Trauma Intensive Care Unit, and a Trauma Observation Area. Trauma attending physicians are present in the hospital 24/7. In addition to providing comprehensive care for injured patients, the Trauma Unit is committed to violence prevention and outreach efforts through ties with several community organizations, including those dealing with gang violence.

NURSING SERVICES

The full scope of nursing care, treatment, and services is provided throughout the hospital on all inpatient units (medical/surgical, maternal child, critical care), in perioperative/operative areas, in the ED, and in areas providing diagnostic and/or specialty services (e.g., Radiology, Dialysis, Infusion Center). Nursing care and services are provided through a mix of Registered Nurses (RN), License Practical Nurses (LPN), Nurses Aides (PCA), Unit Clerks and Child Life Activity Workers. The hospital's nurse executive is responsible for the provision of nursing services 24 hours a day, 7 days a week.

CONSULTING and/or CLINICAL SUPPORT SERVICES

Anesthesia and Pain Management: Anesthesia services across the spectrum of care (e.g., adult, obstetrical, pediatric, neonatal, critical care, trauma) are available 24/7. In addition, the hospital provides inpatient and outpatient pain management services.

Radiology: Diagnostic radiology services (general, trauma, pediatrics, sectional imaging, abdominal imaging) are available 24/7. The hospital also provides mammography services, nuclear medicine services, radiation oncology services, and interventional/radiology special procedures services.

Psychiatry: The hospital is not a primary provider of psychiatric or behavioral health services; there is no inpatient psychiatric unit. Additionally, the hospital is not a primary provider of substance or alcohol abuse services. Psychiatry services are consult-based, and divided into four service areas: Inpatient Consultation Service, Child Consultation Service, Substance Abuse SBIRT Service, and Emergency Consultation Service.

Child Protective Services: Child abuse and neglect evaluations are provided by the Division of Child Protective Services (CPS) in the Department of Pediatrics. CPS evaluations by a team of physicians, along with a multidisciplinary team of nurses and social workers, are available 24/7 for all children presenting to the hospital who are suspected of being abused/neglected. All pediatric trauma and burn patients receive mandatory consultation.

Palliative Care Services: Palliative Care Services are provided under the aegis of the Department of Medicine. Palliative care consultations are available to all services in the hospital (including neonatal, pediatric and adult medical, surgical and obstetric and gynecology services, as well as all intensive care units). Inpatient consultations are available 7 days a week, 365 days a year. Outpatient palliative care consultations are available in the Palliative Care Clinic.

ADDITIONAL SUPPORTING SERVICES

Pathology and Clinical Laboratory: The hospital has a CAP (College of American Pathologists)-accredited laboratory and maintains a current CLIA certificate. Services are available 24/7. The laboratory performs Chemistry, Hematology, Coagulation, Urinalysis, Microbiology, Immunology, Virology, Molecular and Flow Cytometry. Pathologists provide anatomic pathology and cyto-pathology services, and perform autopsies. The department also manages the Point of Care (POC) testing throughout the Hospital.

Blood Banking Services: The hospital has a director and in-house blood bank technicians who are available 24/7 for blood banking procedures. The blood bank is in compliance with all of the regulatory agencies for oversight and is certified by CAP and AABB, and is FDA registered.

Pharmaceutical Services: Pharmaceutical services are available 24/7. In addition to the main Inpatient Pharmacy, the hospital staffs a Surgery Pharmacy and an Infusion Center Pharmacy, as well as an Outpatient Pharmacy and Fantus Clinic Pharmacy. A complete intravenous admixture program and a unit dose medication delivery system are provided. Pharmaceutical staff and information systems are available to support clinicians with their pharmaceutical decision-making. In addition, specialized pharmacy clinical staff work in areas with complex and high risk medication therapy including the emergency room, trauma, oncology, pediatrics, surgery, intensive care, anticoagulation and medicine.

Respiratory Care Services: The Department of Respiratory Care operates 24/7 in all inpatient and outpatient areas of the hospital, i.e., in all adult and pediatric general and critical care units, as well as the ED and specialty clinics.

PT, OT, Physical Medicine: The Occupational and Physical Therapy Department provides occupational and physical therapy services and durable medical equipment across the continuum of care to inpatients and outpatients at the hospital.

Speech, Language, and Hearing Services: Language, Speech, and Hearing services are provided for pediatric and adult patients with communication disorders, as well as for those at high risk for these disorders. Audiologically, patients of all ages with a suspected hearing problem and/or at risk for hearing impairment secondary to specific illnesses, ototoxic drugs, etc., also are evaluated and served by this department.

Dietary: The Department of Nutrition and Foodservices at Stroger Hospital provides nutrition intervention for inpatients and outpatients, patient foodservices, and Cafeteria services for patients, employees, students, and guests. Clinical Dietitians perform assessments, patient education, monitoring and follow-up for patients on general, therapeutic, enteral, and parenteral diets.

Interpreter Services: The Department of Interpreter Services provides interpretation and written translation services for Limited English Proficient patients and their families 24/7 (at no cost to them), and ensures compliance with federal, state and local mandates for language assistance to patients. In addition to staff interpreters (Spanish, Polish, and Chinese), the Department meets the language assistance needs of patients through the use of a telephonic interpreter service, an Internal Language Bank, volunteers and student interns, and an outside agency that specializes in health care interpreting.

Social Services: The Department of Social Work provides the full range of social work services and discharge planning for inpatients. Additionally the department provides emergency social work services and crisis intervention to patients in the emergency room.

Domestic Violence Services: Domestic violence services are provided via Hospital Crisis Intervention Project (HCIP) personnel. HCIP is on-site at the hospital Monday through Friday from 8:00 a.m. until 9:00 p.m., and available via pager 24/7. HCIP serves male and female victims of domestic violence; services include crisis intervention, individual counseling, legal and medical advocacy, access to emergency shelters, safety planning, and referrals to additional resources.

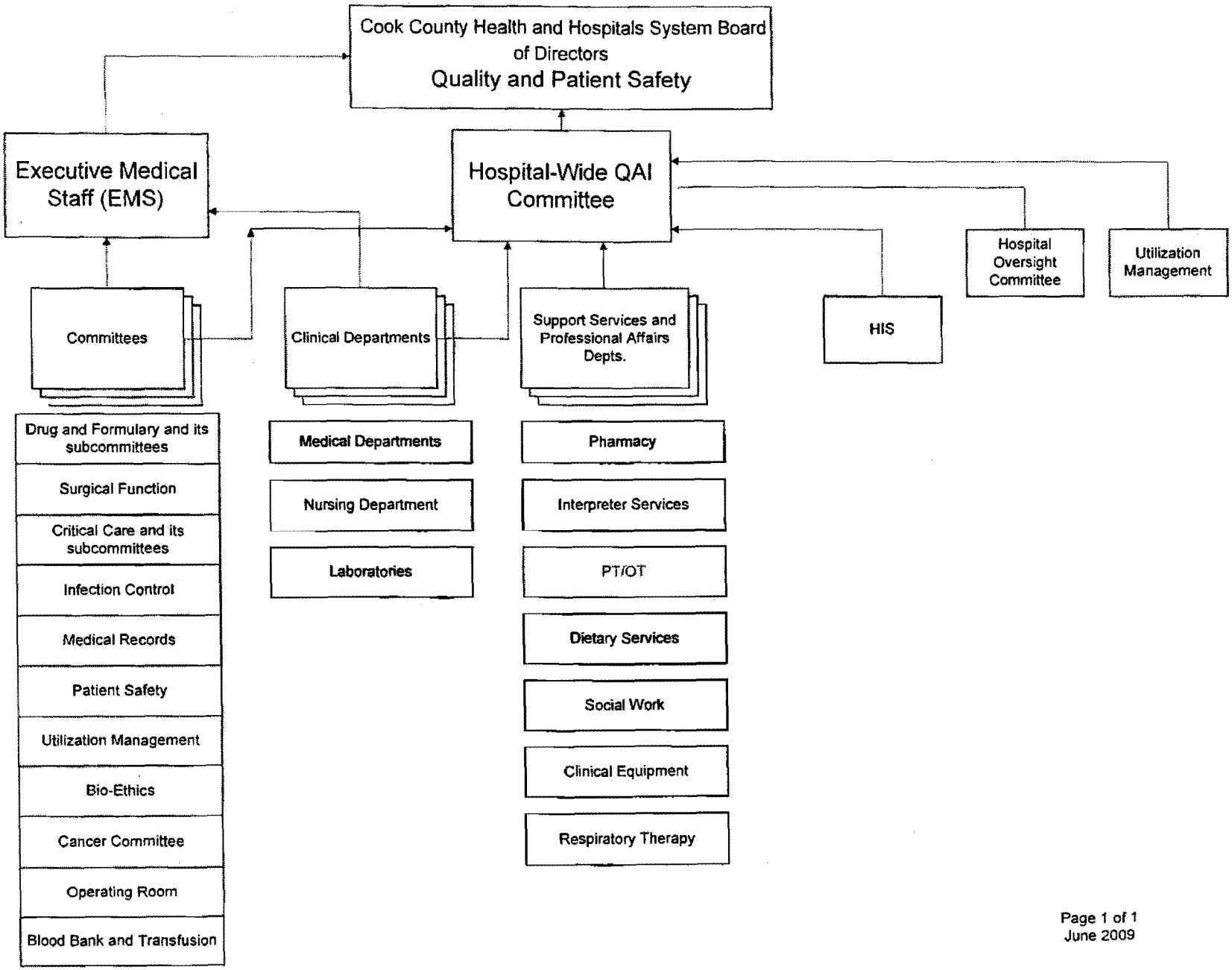
Medical Advocate and Legal Advocate of Rape Victim Advocates (RVA): Medical and legal advocacy services for victims of sexual assault are provided by RVA personnel. RVA is on-site at the Stroger campus (Fantus Health Center) Monday through Friday, and available 24/7 for crisis intervention in the emergency room. RVA provides information about the medical evidence collection process, provides referrals for support services and assists with legal issues.

Pastoral Care Services: Volunteer chaplains and chaplain assistants are available for visiting, counseling, and comforting patients and their families, with 24-hour availability offered by Baptist and Catholic chaplains. Respect for all religious traditions is maintained. The hospital has an on-site chapel.

ADMINISTRATION SUPPORT

On-Duty Administrator: The hospital is supported by an On-Duty Administrator (ODA) 24/7 who functions to ensure the effective and efficient operation of hospital systems. The ODA serves as an administrative liaison between departments and with external agencies. The ODA is responsible for Patient Care issues, as well as Disaster, Fire, and Safety issues, and has direct access to the Deputy Hospital Director or the Chief Operating Officer.

Reporting Structure
John H. Stroger Jr. Hospital of Cook County
Quality Assurance



HOSPITAL OVERSIGHT COMMITTEE

PATIENT CARE REVIEWS

SENTINEL EVENTS/NEAR MISSES

HOSPITAL ACQUIRED CONDITIONS

MULTIDEPARTMENT ISSUES

HOSPITAL QUALITY ASSURANCE COMMITTEE

DEPARTMENT REPORTS

- Scope of Service
- Populations Served
- Population Needs
- Indicators

(Medical Departments)

Departmental Oversight Committees
Blood Use
Surgical Case Review
Medical Record Reviews

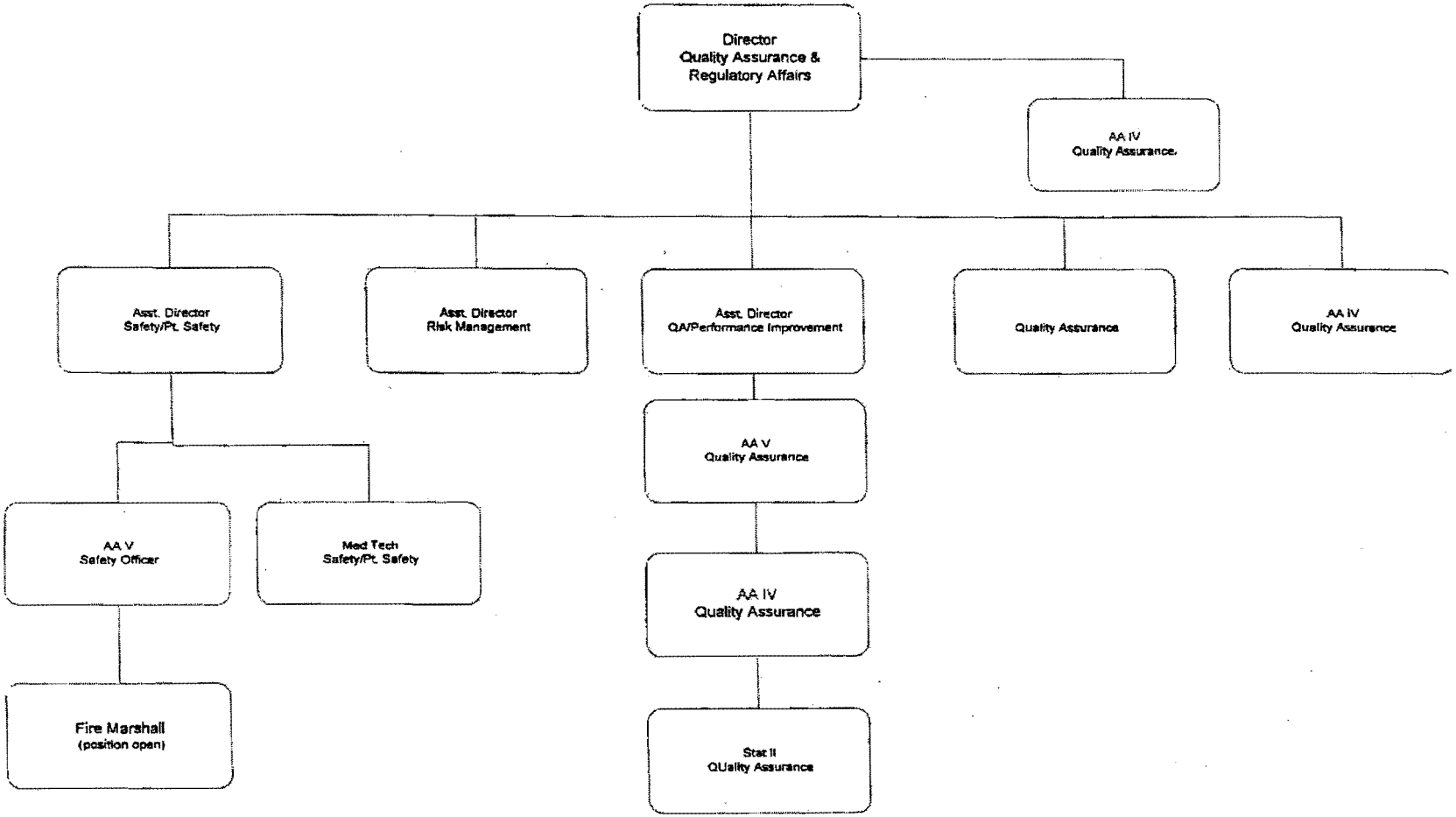
MEDICAL STAFF AND ADMINISTRATIVE COMMITTEE REPORTS

Committee Charge
Accomplishments
Goals/Needs
Attendance

OTHER REPORTS

- Medication Errors
- Incidents
- Organ Donor
- Sentinel Events
- Hospital Acquired Conditions
- Core Measures
- Patient Satisfaction
- Patient Falls
- Skin Integrity
- Regulatory Bodies
- Hospital Oversight Committee

Quality Assurance-Regulatory Affairs/Risk Management/Safety and Patient Safety



RISK MANAGEMENT

CLINICAL SURVEILLANCE/IDENTIFICATION OF POTENTIAL LITIGATION

ADVERSE EVENTS/NEAR MISS INVESTIGATION & CASE REVIEW

ROOT CAUSE ANALYSES

24 HOUR PAGER FOR Q&A's

MALPRACTICE CLAIMS HISTORY FOR EMPLOYEES/TRAINEES

LITIGATION SUPPORT

SUPOENA COORDINATION

REVIEW OF RECORDS BEFORE RELEASE TO STATES ATTORNEY OFFICE

INCIDENT REPORT REVIEW/ANALYSIS

POLICY DEVELOPMENT

REVIEW AND ADVISE ON PATIENT COMPLAINTS AND EMPLOYEE HEALTH ISSUES

PATIENT SAFETY

MEDICATION ERROR REPORTS AND ANALYSIS

PATIENT SAFETY SURVELLIANCE

POLICY DEVELOPMENT

REGULATORY COMPLIANCE

NATIONAL PATIENT SAFETY GOALS

PATIENT SAFETY COMMITTEE

PI RELATED TO PATIENT SAFETY

STAFF EDUCATION/SURVEYS

PATIENT SAFETY ROUNDS

INCIDENT REPORT DATA

Safety Department

Fire Drills conducted quarterly on all 3 shifts for Stroger Hospital (minimum of 9/quarter) Fantus Clinic has drills on 2 shifts (4/quarter). Core Center has 2 drills per year. Hektoen, Durand, and Administration Building have one drill per year.

Training conducted for complex on various topics including fire safety, emergency response, etc.

Training performed for Physically Challenged employees on complex once a year.

Training Programs developed. All training programs on web site are reviewed/revised every year (16 programs). There are numerous other training programs also.

Disaster Manual policies developed, as well as all policies (118 policies) reviewed/revised every three years (per Joint).

Chemical testing performed on the complex annually (ETO, Glutaraldehyde, formaldehyde, xylene, etc.).

Construction site review daily (all projects on complex).

Oversight of Environment of Care (EOC) Program including:

1. agenda for EOC Committee
2. minutes for EOC Committee
3. reports for EOC Committee
4. write management plans for three sections of the EOC program
5. write annual evaluations for three sections of the EOC program

Respond to employee complaints.

Respond to OSHA visits due to employee complaints.

Respond to and critique all internal emergencies.

Review all employee work injury/illness reports.

Review and approve all contract specifications for medical supplies.

Coordinate chemical removal on complex.

Review and approve all chemical removal invoices.

Perform hazard surveillance rounds on the complex per Joint requirements (semiannual inspection of Stroger, Fantus, Core Center; annual inspection of Hektoen, Durand and Administration Building).

Maintain numerous books of reports including: all fire alarms, fire drills, manifests of chemicals, EOC books, chemical testing reports, Material Safety Data Sheets (MSDS), etc.

On call 24 hours a day, seven days a week

PERFORMANCE IMPROVEMENT ACTIVITIES

Clinical Performance Data
AMI
Pneumonia
Heart Failure
SCIP
OB- Delivery
Mortality
Re-admissions
AHRQ
HCAHPS
OutPt SCIP
SCIP Infections to IDPH

Hospital Acquired Conditions
Tracking and Evaluation of Care

Regulatory Compliance
Corrective Action Plans – Development and Monitoring Compliance (Laboratory, Dialysis)

Information Management
Development and Support of Cerner
Electronic Data and Measures Reporting
Clinical Decision Support

Performance Improvement Teams
Communication
Patient Satisfaction - CCHHS
Laboratory Services – Corrective Action Plan
UB-04 Data Accuracy / Compdata
Nursing Cerner Documentation
Fall Prevention Program
Rapid Response
HW- Policy Update
NEW Anti-coagulation CCHHS
NEW Inpatient and Out Patient Diabetes - CCHHS
NEW – Stroke Care
NEW Tracer Assessment (TJC Preparedness)

Medical Staff Committees:

Blood and Transfusion
Medical Records
Medical Information/Clinical Documentation
Surgical Function Review

Critical Care
Resuscitation
Ethics
Infection Control
Drug and Formulary
Anti-infective
Drug Use Evaluation
Operating Room
Cancer

Nursing Committees:

Quality addressing NPSG

JOHN H. STROGER, JR HOSPTIAL
CORE MEASURES

Inpatient Measures	Submitted to TJC	Submitted to CMS	Submitted to IDPH
AMI	X	X	
Pneumonia		X	
Heart Failure	X	X	
SCIP	X	X	X
Preg. measures	X		
Mortality Measures		X	
Readmission measures		X	
AHRQ measures		X	
HCAHPS		X	
Outpatient measures		X	

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J H Stroger Hospital of Cook County

Hospital Quality Measures for Last 6 Quarter Calendar Year (CY)
Acute Myocardial Infarction (AMI)

		2007 (CY) Quarter 2	2007 (CY) Quarter 3	2007 (CY) Quarter 4	2008 (CY) Quarter 1	2008 (CY) Quarter 2	2008 (CY) Quarter 3 (1)	Aggregate Rate (For All Six Quarters) (2)	Target: IL Avg (3)	Target: Nat'l Avg (3)
AMI-1	Aspirin at Arrival	97% of 38 patient(s)	92% of 50 patient(s)	93% of 29 patient(s)	93% of 28 patient(s)	100% of 46 patient(s)	100% of 37 patient(s)	[redacted]	93%	94%
AMI-2	Aspirin Prescribed at Discharge	100% of 46 patient(s)	100% of 58 patient(s)	100% of 34 patient(s)	98% of 46 patient(s)	100% of 64 patient(s)	90% of 52 patient(s)	[redacted]	91%	92%
AMI-3	ACEI or ARB for LVSD	100% of 8 patient(s)*	100% of 11 patient(s)*	100% of 4 patient(s)*	88% of 8 patient(s)*	100% of 15 patient(s)*	92% of 12 patient(s)*	[redacted]	86%	90%
AMI-4	Adult Smoking Cessation Advice/Counseling	100% of 29 patient(s)	93% of 42 patient(s)	96% of 27 patient(s)	89% of 28 patient(s)	80% of 20 patient(s)*	78% of 18 patient(s)*	91%	91%	94%
AMI-5	Beta Blocker Prescribed at Discharge	98% of 42 patient(s)	98% of 59 patient(s)	96% of 27 patient(s)	93% of 43 patient(s)	94% of 62 patient(s)	96% of 50 patient(s)	[redacted]	93%	93%
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	-	-	-	-	-	-	-	28%	40%
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	14% of 7 patient(s)*	12% of 8 patient(s)*	0% of 5 patient(s)*	0% of 5 patient(s)*	50% of 2 patient(s)*	33% of 6 patient(s)*	[redacted]	67%	72%

(1) Data is pending appraisal from Illinois Hospital Association COMPData

(2) Red is below national/state averages; Yellow matches national/state averages; Green is above national/state averages.

(3) Averages are based on Hospital Quality Alliance data from 2007 Quarter 3 through 2008 Quarter 2

(*) The number of cases is too small (n<25) for purposes of reliably predicting hospital performance

J H Stroger Hospital of Cook County

Hospital Quality Measures for Last 6 Quarter Calendar Year (CY)
Heart Failure (HF)

		2007 (CY) Quarter 2	2007 (CY) Quarter 3	2007 (CY) Quarter 4	2008 (CY) Quarter 1	2008 (CY) Quarter 2	2008 (CY) Quarter 3 (1)	Aggregate Rate (For All Six Quarters) (2)	Target: IL Avg (3)	Target: Nat'l Avg (3)
HF-1	Discharg[redacted]ons	70% of 70 patient(s)	76% of 66 patient(s)	73% of 70 patient(s)	76% of 71 patient(s)	82% of 72 patient(s)	64% of 74 patient(s)	73%	78%	73%
HF-2	[redacted]ion of LVS Function	100% of 68 patient(s)	99% of 71 patient(s)	100% of 75 patient(s)	97% of 71 patient(s)	99% of 73 patient(s)	99% of 75 patient(s)	[redacted]	92%	88%
HF-3	ACEI or ARB for LVSD	100% of 25 patient(s)	88% of 26 patient(s)	97% of 30 patient(s)	100% of 26 patient(s)	94% of 32 patient(s)	100% of 32 patient(s)	[redacted]	88%	88%
HF-4	Adult S[redacted]oking Cessation Advice/C[redacted]ounseling	94% of 31 patient(s)	87% of 31 patient(s)	90% of 31 patient(s)	92% of 25 patient(s)	65% of 31 patient(s)	79% of 24 patient(s)*	[redacted]	92%	90%

(1) Data is pending appraisal from Illinois Hospital Association COMPData

(2) Red is below national/state a erages; Yellow matches national/state averages; Green is above national/state averages.

(3) Averages are based on Hospital Quality Alliance data from 2007 Quarter 3 through 2008 Quarter 2

(*) The number of cases is too small (n<25) for purposes of reliably predicting hospital performance

J H Stroger Hospital of Cook County

Hospital Quality Measures for Last 6 Quarter (Calendar Year)
Pneumonia Care (PN)

		2007 (CY) Quarter 2	2007 (CY) Quarter 3	2007 (CY) Quarter 4	2008 (CY) Quarter 1	2008 (CY) Quarter 2	2008 (CY) Quarter 3 (1)	Aggregate Rate (For All Six Quarters) (2)	Target: IL Avg (3)	Target: Nat'l Avg
PN-1	Oxygenation Assessment	100% of 46 patient(s)	100% of 50 patient(s)	100% of 44 patient(s)	100% of 40 patient(s)	100% of 44 patient(s)	98% of 49 patient(s)		99%	99%
PN-2	Pneumococcal Vaccination	17% of 12 patient(s)*	8% of 13 patient(s)*	20% of 15 patient(s)*	27% of 11 patient(s)*	11% of 9 patient(s)*	60% of 10 patient(s)*		79%	81%
PN-3b	Blood Cultures Performed in [redacted] Department Prior to Initial Antibiotic Received in Hospital	83% of 30 patient(s)	60% of 35 patient(s)	73% of 37 patient(s)	69% of 29 patient(s)	70% of 30 patient(s)	87% of 23 patient(s)*		91%	90%
PN-4	Adult Smoking Cessation Advice/Counseling	86% of 29 patient(s)	70% of 30 patient(s)	71% of 24 patient(s)*	70% of 27 patient(s)	52% of 23 patient(s)*	68% of 22 patient(s)*		87%	87%
PN-5c	Initial Antibiotic Received Within 6 Hours of Hospital Arrival	55% of 42 patient(s)	38% of 47 patient(s)	64% of 39 patient(s)	49% of 39 patient(s)	51% of 41 patient(s)	48% of 48 patient(s)		93%	93%
PN-6	Initial Antibiotic Selection for CAP in Immunocompetent Patient	71% of 24 patient(s)*	41% of 29 patient(s)	58% of 19 patient(s)*	56% of 32 patient(s)	42% of 31 patient(s)	69% of 32 patient(s)		87%	87%
PN-7	Influenza Vaccination	-	-	30% of 30 patient(s)	61% of 31 patient(s)	-	-		77%	79%

(1) Data is pending appraisal from Illinois Hospital Association COMPData

(2) Red is below national/state averages; Yellow matches national/state averages; Green is above national/state averages.

(3) Averages are based on Hospital Quality Alliance data from 2007 Quarter 3 through 2008 Quarter 2

(*) The number of cases is too small (n<25) for purposes of reliably predicting hospital performance

J H Stroger Hospital of Cook County

Hospital Quality Measures for Last 6 Quarter (Calendar Year)
Surgical Care Improvement Project (SCIP)

		2007 (CY) Quarter 2	2007 (CY) Quarter 3	2007 (CY) Quarter 4	2008 (CY) Quarter 1	2008 (CY) Quarter 2	2008 (CY) Quarter 3 (*)	Aggregate Rate (For All Six Quarters) (*)	Target: IL Avg (*)	Target: Nat'l Avg (*)
SCIP-Inf-1	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision	93% of 67 patient(s)	96% of 70 patient(s)	82% of 39 patient(s)	85% of 55 patient(s)	93% of 74 patient(s)	91% of 65 patient(s)		87%	86%
SCIP-Inf-2	Prophylactic Antibiotic Selection for Surgical Patients	99% of 67 patient(s)	99% of 69 patient(s)	100% of 33 patient(s)	98% of 58 patient(s)	93% of 76 patient(s)	98% of 66 patient(s)		93%	92%
SCIP-Inf-3	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End	90% of 62 patient(s)	91% of 66 patient(s)	91% of 32 patient(s)	93% of 54 patient(s)	82% of 73 patient(s)	85% of 62 patient(s)		81%	84%
SCIP-Inf-4	Cardiac Surgery Patients with Controlled 6 A.M. Postoperative Serum Glucose	na	na	na	95% of 19 patient(s)*	88% of 24 patient(s)*	78% of 23 patient(s)*	87%	89%	85%
SCIP-Inf-6	Surgery Patients with Appropriate Hair Removal	na	na	na	95% of 113 patient(s)	97% of 137 patient(s)	96% of 131 patient(s)		95%	95%
SCIP-VTE-1	Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered	92% of 49 patient(s)	95% of 56 patient(s)	94% of 36 patient(s)	98% of 47 patient(s)	93% of 87 patient(s)	90% of 91 patient(s)		85%	84%
SCIP-VTE-2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery	82% of 49 patient(s)	89% of 56 patient(s)	92% of 36 patient(s)	91% of 47 patient(s)	77% of 87 patient(s)	84% of 91 patient(s)		81%	81%

(1) Data is pending appraisal from Illinois Hospital Association COMPData
(2) Red is below national/state averages; Yellow matches national/state averages; Green is above national/state averages.
(3) Averages are based on Hospital Quality Alliance data from 2007 Quarter 3 through 2008 Quarter 2
(*) The number of cases is too small (n<25) for purposes of reliably predicting hospital performance
(na) Indicates that data was not reported from Hospital Quality Alliance for this quarter. Reporting for SCIP-Inf-4 and SCIP rasstarted

Cook County Bureau of Health

Hospital Patient Satisfaction for Last 6 Quarter Calendar Year (CY)
Global Rating

J H Stroger Hospital

	2007 (CY)* Quarter 3	2007 (CY)* Quarter 4	2008 (CY)* Quarter 1	2008 (CY)* Quarter 2	2008 (CY)* Quarter 3	2008 (CY)* Quarter 4	Aggregate Rate (For All Six Quarters)[1]	Target: IL Avg [2]	Target: Nat'l Avg [2]
Overall Rating (9-10 Rating)	56% of 27 response(s)	45% of 86 response(s)	56% of 117 response(s)	58% of 279 response(s)	50% of 331 response(s)	36% of 25 response(s)		61%	64%
Willingness to Recommend this Hospital (Definitely Yes)	74% of 27 response(s)	60% of 87 response(s)	61% of 115 response(s)	63% of 283 response(s)	60% of 329 response(s)	64% of 25 response(s)		65%	68%

Oak Forest Hospital

	2007 (CY)* Quarter 3	2007 (CY)* Quarter 4	2008 (CY)* Quarter 1	2008 (CY)* Quarter 2	2008 (CY)* Quarter 3	2008 (CY)* Quarter 4	Aggregate Rate (For All Six Quarters)[1]	Target: IL Avg [2]	Target: Nat'l Avg [2]
Overall Rating (9-10 Rating)	57% of 79 response(s)	68% of 99 response(s)	64% of 122 response(s)	58% of 134 response(s)	60% of 134 response(s)	69% of 108 response(s)	63%	61%	64%
Willingness to Recommend this Hospital (Definitely Yes)	59% of 85 response(s)	68% of 112 response(s)	63% of 134 response(s)	73% of 134 response(s)	62% of 135 response(s)	67% of 106 response(s)	66%	65%	68%

Provident Hospital

	2007 (CY)* Quarter 3	2007 (CY)* Quarter 4	2008 (CY)* Quarter 1	2008 (CY)* Quarter 2	2008 (CY)* Quarter 3	2008 (CY)* Quarter 4	Aggregate Rate (For All Six Quarters)[1]	Target: IL Avg [2]	Target:
Overall Rating (9-10 Rating)	47% of 178 response(s)	47% of 121 response(s)	43% of 136 response(s)	43% of 86 response(s)	46% of 78 response(s)	41% of 66 response(s)		61%	64%
Willingness to Recommend this Hospital (Definitely Yes)	44% of 181 response(s)	43% of 122 response(s)	44% of 138 response(s)	50% of 88 response(s)	52% of 79 response(s)	39% of 67 response(s)		65%	68%

(*) Data is based on surveys conducted by Press-Ganey.
(1) Aggregate rate is based on averages from the Press-Ganey monthly results.
Red is below national/state averages; Yellow matches national/state averages; Green is above national/state averages
(2) State and national averages are based on Hospital Quality Alliance data from Third Quarter 2007 through Second Quarter 2008

J H Stroger Hospital of Cook County

Hospital Patient Satisfaction for Last 6 Quarter Calendar Year (CY)
Communication and Responsiveness

	2007 (CY)* Quarter 3	2007 (CY)* Quarter 4	2008 (CY)* Quarter 1	2008 (CY)* Quarter 2	2008 (CY)* Quarter 3	2008 (CY)* Quarter 4	Aggregate Rate (For All Six Quarters)[1]	Target: IL Avg [2]	Target: Nat'l Avg [2]
Communication with Nurses (Always)	70%	60%	59%	67%	64%	67%	[redacted]	72%	74%
Communication with Doctors (Always)	82%	79%	81%	79%	80%	80%	79%	79%	80%
Responsiveness of Hospital Staff (Always)	62%	46%	48%	49%	48%	59%	[redacted]	59%	62%
[redacted]	62%	56%	57%	60%	67%	69%	[redacted]	66%	68%
Communication about Medicines (Always)	71%	53%	54%	58%	55%	70%	57%	57%	59%

(*) Data is based on surveys conducted by Press-Ganey. The percentage reflects a composite score based on responses to several questions.
(1) Aggregate rate is based on averages from the Press-Ganey monthly results.
Red is below national/state averages; Yellow matches national/state averages; Green is above national/state averages
(2) State and national averages are based on Hospital Quality Alliance data from Third Quarter 2007 through Second Quarter 2008.

Cook County Bureau of Health

Hospital Patient Satisfaction for Last 6 Quarter Calendar Year (CY)
Hospital Environment

J H Stroger Hospital

	2007 (CY)* Quarter 3	2007 (CY)* Quarter 4	2008 (CY)* Quarter 1	2008 (CY)* Quarter 2	2008 (CY)* Quarter 3	2008 (CY)* Quarter 4	Aggregate Rate (For All Six Quarters)[1]	Target: IL Avg [2]	Target: Nat'l Avg [2]
Cleanliness of Hospital (Always)	50% of 28 response(s)	52% of 86 response(s)	53% of 118 response(s)	52% of 279 response(s)	46% of 327 response(s)	50% of 26 response(s)		68%	69%
Quietness of Hospital (Always)	62% of 26 response(s)	55% of 86 response(s)	55% of 118 response(s)	61% of 279 response(s)	56% of 329 response(s)	67% of 27 response(s)		53%	56%

Oak Forest Hospital

	2007 (CY)* Quarter 3	2007 (CY)* Quarter 4	2008 (CY)* Quarter 1	2008 (CY)* Quarter 2	2008 (CY)* Quarter 3	2008 (CY)* Quarter 4	Aggregate Rate (For All Six Quarters)[1]	Target: IL Avg [2]	Target: Nat'l Avg [2]
eanliness of Hospital (Always)	62% of 86 response(s)	73% of 113 response(s)	63% of 136 response(s)	70% of 135 response(s)	62% of 132 response(s)	66% of 108 response(s)		68%	69%
uietness of Hospital (Always)	56% of 87 response(s)	54% of 112 response(s)	56% of 132 response(s)	61% of 134 response(s)	61% of 133 response(s)	56% of 108 response(s)		53%	56%

Provident Hospital

	2007 (CY)* Quarter 3	2007 (CY)* 4	2008 (CY)* Quarter 1	2008 (CY)* Quarter 2	2008 (CY)* Quarter 3	2008 (CY)* Quarter 4	Aggregate Rate (For All Six Quarters)[1]	Target: IL Avg [2]	Target: Nat'l Avg [2]
eanliness of Hospital (Always)	59% of 182 response(s)	67% of 123 response(s)	55% of 134 response(s)	50% of 86 response(s)	61% of 79 response(s)	54% of 63 response(s)		68%	69%
ss of Hospital (Alw	63% of 179 response(s)	61% of 122 response(s)	64% of 132 response(s)	60% of 84 response(s)	68% of 78 response(s)	55% of 65 response(s)		53%	56%

(*) Data is based on surveys conducted by Press-Ganey.
(1) Aggregate rate is based on averages from the Press-Ganey monthly results.
Red is below national/state averages; Yellow matches national/state averages; Green is above national/state averages
(2) State and national averages are based on Hospital Quality Alliance data from Third Quarter 2007 through Second Quarter 2008.

Cook County Bureau of Health

Hospital Patient Satisfaction for Last 6 Quarter Calendar Year (CY)
Discharge Information

J H Stroger Hospital

	2007 (CY)* Quarter 3	2007 (CY)* Quarter 4	2008 (CY)* Quarter 1	2008 (CY)* Quarter 2	2008 (CY)* Quarter 3	2008 (CY)* Quarter 4	Aggregate Rate (For All Six Quarters)[1]	Target: IL Avg [2]	Target: Nat'l Avg [2]
Discharge Information (Yes)	87%	77%	78%	75%	73%	68%		79%	80%

Oak Forest Hospital

	2007 (CY)* Quarter 3	2007 (CY)* Quarter 4	2008 (CY)* Quarter 1	2008 (CY)* Quarter 2	2008 (CY)* Quarter 3	2008 (CY)* Quarter 4	Aggregate Rate (For All Six Quarters)[1]	Target: IL Avg [2]	Target: Nat'l Avg [2]
Discharge Information (Yes)	75%	76%	70%	80%	74%	76%		79%	80%

Provident Hospital

	2007 (CY)* Quarter 3	2007 (CY)* Quarter 4	2008 (CY)* Quarter 1	2008 (CY)* Quarter 2	2008 (CY)* Quarter 3	2008 (CY)* Quarter 4	Aggregate Rate (For All Six Quarters)[1]	Target: IL Avg [2]	Target: Nat'l Avg [2]
Discharge Information (Yes)	73%	71%	68%	69%	72%	62%		79%	80%

(*) Data is based on surveys conducted by Press-Ganey. The percentage reflects a composite score based on responses to several questions.
(1) Aggregate rate is based on averages from the Press-Ganey monthly results.
Red is below national/state averages; Yellow matches national/state averages; Green is above national/state averages
(2) State and national averages are based on Hospital Quality Alliance data from Third Quarter 2007 through Second Quarter 2008.

Core Quality Measures

January, 2008 through June, 2008 (Year-to-Date)

TARGET KEY: BETTER THAN EXPECTED | EXPECTED | WORSE THAN EXPECTED | N/A or NO PATIENTS

Acute Myocardial Infarction (AMI) Care

Detail	Quality Measure Description	J H Stroger Hospital	Oak Forest Hospital	Provident Hospital
AMI-1	Aspirin at Arrival	■	■	
AMI-2	Aspirin Prescribed at Discharge	■	■	■
AMI-3	ACEI or ARB for LVSD	■	■	■
AMI-4	Adult Smoking Cessation Advice/Counseling	■		■
AMI-5	Beta Blocker Prescribed at Discharge	■	■	■
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival			
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	■		

Pneumonia (PN) Care

Quality Measure Description		J H Stroger Hospital	Oak Forest Hospital	Provident Hospital
PN-1	Oxygenation Assessment	■	■	■
PN-2	Pneumococcal Vaccination	■	■	■
PN-3b	Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital	■	■	■
PN-4	Adult Smoking Cessation Advice/Counseling	■	■	■
PN-5c	Initial Antibiotic Received Within 6 Hours of Hospital Arrival	■	■	■
PN-6	Initial Antibiotic Selection for CAP in Immunocompetent Patient	■	■	■
PN-7	Influenza Vaccination	■		■

Heart Failure (HF) Care

Quality Measure Description		J H Stroger Hospital	Oak Forest Hospital	Provident Hospital
HF-1	Discharge Instructions	■	■	
HF-2	Evaluation of LVS Function	■	■	■
HF-3	ACEI or ARB for LVSD	■	■	■
HF-4	Adult Smoking Cessation Advice/Counseling	■	■	■

Surgical Care Improvement Project (SCIP)

Quality Measure Description		J H Stroger Hospital	Oak Forest Hospital	Provident Hospital
SCIP-Inf-1	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision	■	■	
SCIP-Inf-2	Prophylactic Antibiotic Selection for Surgical Patients	■	■	■
SCIP-Inf-3	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time	■	■	■
SCIP-Inf-4	Cardiac Surgery Patients with Controlled 6 A.M. Postoperative Serum Glucose	■		
SCIP-Inf-6	Surgery Patients with Appropriate Hair Removal	■	■	■
SCIP-VTE-1	Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered	■	■	■
SCIP-VTE-2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery	■	■	■

Click on each category Detail link to go to the respective definitions and detail.

Core Quality Measures

January, 2008 through June, 2008 (Year-to-Date)

Acute Myocardial Infarction (AMI) Care

Core Measure	Description	Measure Definition (Pending Review by Quality Assurance)	TARGET	J H STROGER HOSPITAL	OAK FOREST HOSPITAL	PROVIDENT HOSPITAL
AMI-1	Aspirin at Arrival	A measure of the quality of care treating a heart attack. It prevents further clotting in heart attack patients. The rate is calculated by dividing the number of patients given aspirin by the total number of patients in which aspirin was indicated.	> 94% = 93-94% < 93%	97% of 74 patient(s)	100% of 2 patient(s)*	93% of 13 patient(s)*
AMI-2	**Aspirin Prescribed at Discharge**	A measure of the quality in the long term care of patients who have had a heart attack. Maintenance dosing of aspirin on a daily basis is helpful in preventing additional heart attacks. The rate is calculated by dividing the number of patients discharged with a prescription for aspirin by the total number of patients in which aspirin was indicated.	> 92% = 91-92% < 91%	99% of 110 patient(s)	100% of 3 patient(s)*	86% of 7 patient(s)*
AMI-3	**ACEI or ARB for LVSD**	A measure of the quality of care in treating heart attack patients with left ventricular systolic dysfunction. ACE inhibitors prevent further weakening of the heart in patients who already have weakening. The rate is calculated by dividing the number of patients who receive ACE inhibitors by the number of patients who should receive ACE inhibitors.	> 90% = 86-90% < 86%	96% of 23 patient(s)*	100% of 1 patient(s)*	50% of 2 patient(s)*
AMI-4	**Adult Smoking Cessation Advice/ Counseling**	A measure of the quality in the long term care of patients who have had a heart attack. Smoking increases the risk of developing blood clots and heart disease that can result in heart attack, heart failure or stroke. The rate is calculated by dividing the number of patients who received smoking cessation advice by the number of patients who smoke.	> 94% = 91-94% < 91%	85% of 48 patient(s)	-	0% of 1 patient(s)*

Core Quality Measures

January, 2008 through June, 2008 (Year-to-Date)

Acute Myocardial Infarction (AMI) Care						
Core Measure	**Description**	**Measure Definition (Pending Review by Quality Assurance)**	**TARGET**	**J H STROGER HOSPITAL**	**OAK FOREST HOSPITAL**	**PROVIDENT HOSPITAL**
AMI-5	Beta Blocker Prescribed at Discharge	A measure of the quality of care in the long term treatment of a heart attack. Maintenance dosing of a beta blocker is helpful in keeping the heart from beating faster, thereby enhancing its pumping ability. The rate is calculated by dividing the number of patients discharged with a prescription for a beta blocker by the number of patients in which beta blocker is indicated.	> 93% = 93% < 93%	94% of 105 patient(s)	100% of 4 patient(s)*	71% of 7 patient(s)*
AMI-7a	**Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival**	A measure of the quality of care in treating a heart attack Fibrinolytic drugs are medicines that help dissolve blood clots in blood vessels and improve blood flow to the heart The rate is calculated by dividing the number of patients given fibrinolytic therapy by the number of patients in which fibrinolytic therapy is indicated.	> 40% = 28-40% < 28%			
AMI-8a	**Primary PCI Received Within 90 Minutes of Hospital Arrival**	A measure of the quality of care in treating a heart attack Percutaneous Coronary Interventions (PCI) are procedures that open blocked blood vessels and help prevent further heart muscle damage. Improving blood flow to the heart as quickly as possible lessens the damage to the heart muscle. It can increase the chance of surviving a heart attack. The rate is calculated by dividing the number of patients given PCI by the number of patients in which PCI is indicated.	> 72% = 67-72% < 67%	14% of 7 patient(s)*		

Targets and data are based on the most recent Hospital Quality Alliance (HQA) reporting for this period

(*) The number of cases is too small (n<25) for purposes of reliably predicting hospital performance

(-) Indicates zero patients

Core Quality Measures

January, 2008 through June, 2008 (Year-to-Date)

Heart Failure (HF) Care

Core Measure	Description	Measure Definition (Pending Review by Quality Assurance)	TARGET	J.H STROGER HOSPITAL	OAK FOREST HOSPITAL	PROVIDENT HOSPITAL
HF-1	Discharge Instructions	A measure of the quality of care in the long term care of patients who have congestive heart failure (CHF). In CHF, the patient experiences chronic symptoms such as shortness of breath, dizziness and fatigue. Before leaving the hospital, the patient should receive information on managing these symptoms. The rate is calculated by dividing the number of receiving discharge instructions by the number of patients who are discharged home.	> 78% = 73-78% < 73%	79% of 143 patient(s)	86% of 63 patient(s)	76% of 229 patient(s)
HF-2	Evaluation of LVS Function	A measure of the quality of care in diagnosing congestive heart failure. A test is performed to determine if the lower left chamber (1 of 4 chambers) of the heart is pumping appropriately. Dysfunction indicates the heart as a pump is too weak. The rate is calculated by dividing the number of patients with the assessment done by the number of patients in which it should have been done.	> 92% = 88-92% < 88%	98% of 144 patient(s)	98% of 63 patient(s)	97% of 231 patient(s)
HF-3	ACEI or ARB for LVSD	A measure of the quality of care in treating congestive heart failure (CHF). In CHF, the heart is a weak pump and ACE inhibitors prevent further weakening. The rate is determined by dividing the number of patients who receive an ACE inhibitor by the number of patients that should have.	> 88% = 88% < 88%	97% of 58 patient(s)	97% of 35 patient(s)	95% of 102 patient(s)
HF-4	Adult Smoking Cessation Advice/ Counseling	A measure of the quality in the long term care of patients who have congestive heart failure. Smoking increases the risk of developing blood clots and heart disease that can result in heart attack, heart failure or stroke. The rate is calculated by dividing the number of patients who received smoking cessation advice by the number of patients who smoke.	> 92% = 90-92% < 90%	77% of 56 patient(s)	100% of 27 patient(s)	97% of 118 patient(s)

Core Quality Measures

January, 2008 through June, 2008 (Year-to-Date)

Pneumonia (PN) Care

Core Measure	Description	Measure Definition (Pending Review by Quality Assurance)	TARGET	J H STROGER HOSPITAL	OAK FOREST HOSPITAL	PROVIDENT HOSPITAL
PN-1	Oxygenation Assessment	A measure of quality of care in diagnosing patients with CAP. The RN administers a test (pulse oximetry) which determines how saturated the patient's blood is with oxygen. The rate is determined by dividing the number of patients in which the assessment was done by the total number of pneumonia patients.	> 99% = 99% < 99%	100% of 84 patient(s)	100% of 34 patient(s)	100% of 200 patient(s)
PN-2	Pneumococcal Vaccination	A measure of quality of care in preventing pneumonia. A pneumococcal vaccine can prevent future occurrence of pneumonia. If a patient admitted with pneumonia has not had a vaccine (given by a private doctor or convalescent home), the hospital administers the vaccine. The rate is determined by dividing the number of patients in which the vaccine was given by the number of patients eligible for the vaccine.	> 81% = 79-81% < 79%	20% of 20 patient(s)*	100% of 4 patient(s)*	41% of 46 patient(s)
PN-3b	Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital	A measure of quality of care in the treatment of pneumonia. There are different types of bacteria that can cause pneumonia, and a blood culture can help identify which bacteria may have caused the pneumonia. This will also help determine which antibiotic should be prescribed. The rate is determined by dividing the number of patients in which a blood culture was performed by the total number of patient who are first seen in the emergency room.	> 91% = 90-91% < 90%	70% of 59 patient(s)	93% of 30 patient(s)	73% of 175 patient(s)
PN-4	Adult Smoking Cessation Advice/ Counseling	A measure of quality in the long term care of patients who have pneumonia. Smoking damages the lungs, and it is linked to lung cancer, heart disease and stroke. Quitting may reduce the chance of getting pneumonia again. The rate is determined by dividing the number of patients who received smoking cessation advice by the number of patients who smoke.	> 87% = 87% < 87%	62% of 50 patient(s)	96% of 22 patient(s)*	99% of 145 patient(s)

Core Quality Measures

January, 2008 through June, 2008 (Year-to-Date)

Pneumonia (PN) Care

Core Measure	Description	Measure Definition (Pending Review by Quality Assurance)	TARGET	J H STROGER HOSPITAL	OAK FOREST HOSPITAL	PROVIDENT HOSPITAL
PN-5c	Initial Antibiotic Received Within 6 Hours of Hospital Arrival	A measure of quality in the treatment of pneumonia. Antibiotics are used to treat adults with pneumonia caused by bacteria. Early treatment with antibiotics can cure bacterial pneumonia and reduce the possibility of complications. The rate is determined by dividing the number of patients who received antibiotics within 6 hours by the total number of patients eligible for antibiotics.	> 93% = 93% < 93%	50% of 80 patient(s)	86% of 29 patient(s)	73% of 196 patient(s)
PN-6	Initial Antibiotic Selection for CAP in Immunocompetent Patient	A measure of quality in the treatment of pneumonia. Pneumonia is a lung infection that is usually caused by bacteria or a virus. If pneumonia is caused by bacteria, hospitals will treat the infection with antibiotics. The rate is determined by dividing the number of patients who received antibiotic by the total number of immunocompetent patients.	> 87% = 87% < 87%	49% of 83 patient(s)	96% of 27 patient(s)	84% of 149 patient(s)
PN-7	Influenza Vaccination	A measure of quality in preventing pneumonia. Flu shots reduce the risk of influenza, a serious and sometimes deadly lung infection that can spread quickly in a community or facility. An influenza vaccine can protect patients from another lung infection and help prevent the spread of influenza. The rate is determined by dividing the number of patients who received an influenza vaccination by the number of patients eligible for the vaccine.	> 79% = 77-79% < 77%	61% of 31 patient(s)	78% of 9 patient(s)*	32% of 91 patient(s)

Targets and data are based on the most recent Hospital Quality Alliance (HQA) reporting for this period

(*) The number of cases is too small (n<25) for purposes of reliably predicting hospital performance

(-) Indicates zero patients

Core Quality Measures

January, 2008 through June, 2008 (Year-to-Date)

Surgical Care Improvement Project (SCIP)

Core Measure	Description	Measure Definition (Pending Review by Quality Assurance)	TARGET	J.H STROGER HOSPITAL	OAK FOREST HOSPITAL	PROVIDENT HOSPITAL
SCIP-Inf-1	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision	A measure of quality in the prevention of surgical complications. Research shows that surgery patients who get antibiotics within the hour before their operation are less likely to get wound infections. The rate is determined by dividing the number of patients who received antibiotics one hour prior to surgical incision by the total number of patients eligible for antibiotics.	> 87% = 86-87% < 86%	90% of 129 patient(s)	100% of 7 patient(s)*	87% of 23 patient(s)*
SCIP-Inf-2	Prophylactic Antibiotic Selection for Surgical Patients	A measure of quality in the prevention of surgical complications. Certain antibiotics are recommended to help prevent wound infections for particular types of surgery. This measure looks at how often hospital surgical patients get the appropriate antibiotics in order to prevent a surgical wound infection. The rate is determined by dividing the number of patients who received the appropriate antibiotic by the total number of patients receiving antibiotics prior to surgery.	> 93% = 92-93% < 92%	95% of 132 patient(s)	100% of 7 patient(s)*	100% of 22 patient(s)*
SCIP-Inf-3	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time	A measure of quality in the prevention of surgical complications. Taking antibiotics for more than 24 hours after routine surgery is usually not necessary and can increase the risk of side effects, such as stomach aches, serious types of diarrhea and antibiotic resistance. The rate is determined by dividing the number of patients in which antibiotics were discontinued within 24 hours after surgery by the total number of patients receiving antibiotics prior to surgery.	> 84% = 81-84% < 81%	87% of 127 patient(s)	100% of 7 patient(s)*	91% of 22 patient(s)*
SCIP-Inf-4	Cardiac Surgery Patients with Controlled 6 A.M. Postoperative Serum Glucose	A measure of quality in the prevention of surgical complications. Even if heart surgery patients do not have diabetes, keeping their blood sugar under good control after surgery lowers the risk of infection and other problems. "Under good control" means their blood sugar should be 200 mg/dl or less when checked first thing in the morning. The rate is determined by dividing the number of patients in which the blood sugar was under good control after cardiac surgery by the total number of patients who underwent cardiac surgery.	> 89% = 85-89% < 85%	91% of 43 patient(s)		

Core Quality Measures

January, 2008 through June, 2008 (Year-to-Date)

Surgical Care Improvement Project (SCIP)

Core Measure	Description	Measure Definition (Pending Review by Quality Assurance)	TARGET	J H STROGER HOSPITAL	OAK FOREST HOSPITAL	PROVIDENT HOSPITAL
SCIP-Inf-6	Surgery Patients with Appropriate Hair Removal	A measure of quality in the prevention of surgical infections Preparing a patient for surgery may include removing body hair from the skin in the area where the surgery will be done. Medical research has shown that shaving with a razor can increase the risk of infection. It is safer to use electric clippers or hair removal cream. The rate is determined by dividing the number of patients who have a safer method of hair removal by the total number of patients who have hair removal prior to surgery.	> 95% = 95% < 95%	96% of 250 patient(s)	100% of 20 patient(s)*	87% of 54 patient(s)
SCIP-VTE-1	Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered	A measure of quality in the prevention of post-surgical blood clots The risk of developing blood clots can be reduced through preventative treatments such as blood thinning medications, elastic support stockings or mechanical air stockings that promote circulation in the legs. The rate is determined by dividing the number of patients in which thromboembolism prophylaxis is ordered by the number of patients eligible for prophylaxis.	> 85% = 84-85% < 84%	95% of 134 patient(s)	100% of 10 patient(s)*	86% of 37 patient(s)
SCIP-VTE-2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery	A measure of quality in the prevention of post-surgical blood clots. Treatments to prevent blood clots must be given at the right time to prevent blood clots forming after surgery. The rate is determined by dividing the number of patients in which thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery by the number of patients who received thromboembolism prophylaxis.	> 81% = 81% < 81%	82% of 134 patient(s)	100% of 10 patient(s)*	86% of 37 patient(s)

Targets and data are based on the most recent Hospital Quality Alliance (HQA) reporting for this period

(*) The number of cases is too small (n<25) for purposes of reliably predicting hospital performance

(-) Indicates zero patients

34

Measures

Provider: John Stroger Hospital of CC - 140124
Discharge Date Range: 10-01-2008 - 12-31-2008
Measure Set: AMI
Physician: ALL

Total medical records abstracted for AMI:61

Age Breakdown:

Age	N/D	Percent
Mean Age (years):	57	
<65	45/61	73.8%
65-74	10/61	16.4%
75-84	5/61	8.2%
>84	1/61	1.6%

Sex Breakdown:

Sex	N/D	Percent
Male	45/61	73.8%
Female	16/61	26.2%
Unknown	0/61	0.0%

Measures:

Measure	N/D	Percent
AMI-1 Aspirin at Arrival	52/54	96.3%
AMI-2 Aspirin Prescribed at Discharge	53/53	100.0%
AMI-3 ACEI or ARB for LVSD	6/6	100.0%
AMI-4 Adult Smoking Cessation Advice/Counseling	23/27	85.2%
AMI-5 Beta-Blocker Prescribed at Discharge	48/49	98.0%
AMI-6 Beta-Blocker at Arrival	37/46	80.4%
AMI-7 Median Time to Fibrinolysis	0/0	*
AMI-7a Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	0/0	
AMI-8 Median Time to Primary PCI	102 **	
AMI-8a Primary PCI Received Within 90 Minutes of Hospital Arrival	0/2	0.0%

*No cases eligible for inclusion within the denominator.
**The time (in minutes) will be displayed in the N/D column. There will be no percent for this measure because it is a continuous variable.

35

Measures

Provider: John Stroger Hospital of CC - 140124

Discharge Date Range: 10-01-2008 - 12-31-2008

Measure Set: AMI

Physician: ALL

Measure	N/D	Percent
AMI-T1a LDL Cholesterol Assessment (CMS Test)	40/44	90.9%
AMI-T2 Lipid-Lowering Therapy at Discharge (CMS Test)	27/28	96.4%

*No cases eligible for inclusion within the denominator.

**The time (in minutes) will be displayed in the N/D column. There will be no percent for this measure because it is a continuous variable.

37

Measures

Provider: John Stroger Hospital of CC - 140124

Discharge Date Range: 10-01-2008 - 12-31-2008

Measure Set: PN

Physician: ALL

Total medical records abstracted for PN:82

Age Breakdown:

Age	N/D	Percent
Mean Age (years):	53	
<65	63/82	76.8%
65-74	9/82	11.0%
75-84	8/82	9.8%
>84	2/82	2.4%

Sex Breakdown:

Sex	N/D	Percent
Male	54/82	65.9%
Female	28/82	34.1%
Unknown	0/82	0.0%

Measures:

Measure	N/D	Percent
PN-1 Oxygenation Assessment	62/62	100.0%
PN-2 Pneumococcal Vaccination	12/16	75.0%
PN-3a Blood Cultures Performed Within 24 Hours Prior to or 24 Hours After Hospital Arrival for Patients Who Were Transferred or Admitted to the ICU Within 24 Hours of Hospital Arrival	6/8	75.0%
PN-3b Blood Cultures Performed In the Emergency Department Prior to Initial Antibiotic Received in Hospital	25/30	83.3%
PN-4 Adult Smoking Cessation Advice/Counseling	20/33	60.6%
PN-5 Antibiotic Timing (Median) (The Joint Commission)	319 **	
PN-5b Initial Antibiotic Received Within 4 Hours of Hospital Arrival	21/53	39.6%
PN-5c Initial Antibiotic Received Within 6 Hours of Hospital Arrival	29/53	54.7%
PN-6 Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patients (CMS)	23/42	54.8%

*No cases eligible for inclusion within the denominator.

**The time (in minutes) will be displayed in the N/D column. There will be no percent for this measure because it is a continuous variable.

Measures
Provider: John Stroger Hospital of CC - 140124
Discharge Date Range: 10-01-2008 - 12-31-2008
Measure Set: PN
Physician: ALL

Measure	N/D	Percent
PN-6a Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patients - Intensive Care Unit (ICU) Patients (The Joint Commission)	2/4	50.0%
PN-6b Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patients - Non ICU Patients (The Joint Commission)	21/38	55.3%
PN-7 Influenza Vaccination	32/42	76.2%

*No cases eligible for inclusion within the denominator.
**The time (in minutes) will be displayed in the N/D column. There will be no percent for this measure because it is a continuous variable.

Measures

Provider: John Stroger Hospital of CC - 140124
Discharge Date Range: 10-01-2008 - 12-31-2008
Measure Set: SCIP
Physician: ALL

Total medical records abstracted for SCIP:134

Age Breakdown:

Age	N/D	Percent
Mean Age (years):	52	
<65	114/134	85.1%
65-74	18/134	13.4%
75-84	2/134	1.5%
>84	0/134	0.0%

Sex Breakdown:

Sex	N/D	Percent
Male	86/134	64.2%
Female	48/134	35.8%
Unknown	0/134	0.0%

Measures:

Measure	N/D	Percent
SCIP-Inf-1a Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision - Overall Rate	61/66	92.4%
SCIP-Inf-1b Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision - CABG	13/13	100.0%
SCIP-Inf-1c Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision - Other Cardiac Surgery	10/10	100.0%
SCIP-Inf-1d Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision - Hip Arthroplasty	7/8	87.5%
SCIP-Inf-1e Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision - Knee Arthroplasty	0/0	
SCIP-Inf-1f Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision - Colon Surgery	10/14	71.4%
SCIP-Inf-1g Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision - Hysterectomy	11/11	100.0%
SCIP-Inf-1h Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision -	10/10	100.0%

*No cases eligible for inclusion within the denominator.
**The time (in minutes) will be displayed in the N/D column. There will be no percent for this measure because it is a continuous variable.

4/6

Measures

Provider: John Stroger Hospital of CC - 140124

Discharge Date Range: 10-01-2008 - 12-31-2008

Measure Set: SCIP

Physician: ALL

Measure	N/D	Percent
Vascular Surgery	10/10	100.0%
SCIP-Inf-2a Prophylactic Antibiotic Selection for Surgical Patients - Overall Rate	62/68	91.2%
SCIP-Inf-2b Prophylactic Antibiotic Selection for Surgical Patients - CABG	15/15	100.0%
SCIP-Inf-2c Prophylactic Antibiotic Selection for Surgical Patients - Other Cardiac Surgery	10/10	100.0%
SCIP-Inf-2d Prophylactic Antibiotic Selection for Surgical Patients - Hip Arthroplasty	8/8	100.0%
SCIP-Inf-2e Prophylactic Antibiotic Selection for Surgical Patients - Knee Arthroplasty	0/0	
SCIP-Inf-2f Prophylactic Antibiotic Selection for Surgical Patients - Colon Surgery	8/14	57.1%
SCIP-Inf-2g Prophylactic Antibiotic Selection for Surgical Patients - Hysterectomy	11/11	100.0%
SCIP-Inf-2h Prophylactic Antibiotic Selection for Surgical Patients - Vascular Surgery	10/10	100.0%
SCIP-Inf-3a Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time - Overall Rate	49/63	77.8%
SCIP-Inf-3b Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time - CABG	11/13	84.6%
SCIP-Inf-3c Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time - Other Cardiac Surgery	7/8	87.5%
SCIP-Inf-3d Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time - Hip Arthroplasty	7/8	87.5%
SCIP-Inf-3e Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time - Knee Arthroplasty	0/0	
SCIP-Inf-3f Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time - Colon Surgery	11/13	84.6%
SCIP-Inf-3g Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time - Hysterectomy	9/11	81.8%
SCIP-Inf-3h Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time - Vascular Surgery	4/10	40.0%
SCIP-Inf-4 Cardiac Surgery Patients with Controlled 6 A.M. Postoperative Blood Glucose	22/25	88.0%
SCIP-Inf-6 Surgery Patients with Appropriate Hair Removal	126/131	96.2%
SCIP-Inf-7 Colorectal Surgery Patients with Immediate Postoperative Normothermia	12/17	70.6%
SCIP-Card-2 Surgery Patients on Beta-Blocker Therapy Prior to Admission Who Received a Beta-Blocker During the Perioperative Period	23/30	76.7%
SCIP-VTE-1 Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered	60/61	98.4%
SCIP-VTE-2 Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery	54/61	88.5%

*No cases eligible for inclusion within the denominator.

**The time (in minutes) will be displayed in the N/D column. There will be no percent for this measure because it is a continuous variable.

Measures

Provider: John Stroger Hospital of Cook County - 140124

Encounter Date Range: 10-01-2008 - 12-31-2008

Measure Set: HOP-SURGERY

Total medical records abstracted for HOP-SURGERY:54

Age Breakdown:

Age	N/D	Percent
Mean Age (years):	39	
<65	51/54	94.4%
65-74	3/54	5.6%
75-84	0/54	0.0%
>84	0/54	0.0%

Sex Breakdown:

Sex	N/D	Percent
Male	40/54	74.1%
Female	14/54	25.9%
Unknown	0/54	0.0%

Measures:

Measure	N/D	Percent
OP-6 Antibiotic Timing	52/54	96.3%
OP-7 Antibiotic Selection	42/54	77.8%

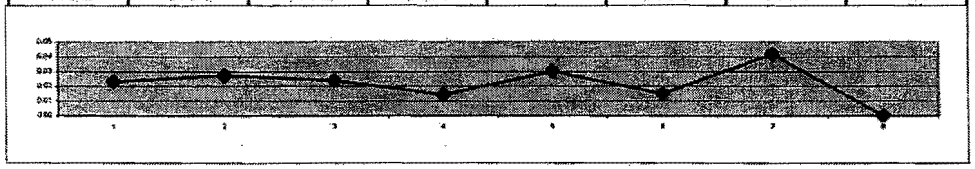
*No cases eligible for inclusion within the denominator.

**The time (in minutes) will be displayed in the N/D column. There will be no percent for this measure because it is a continuous variable.

TJC ORYX MEASURES

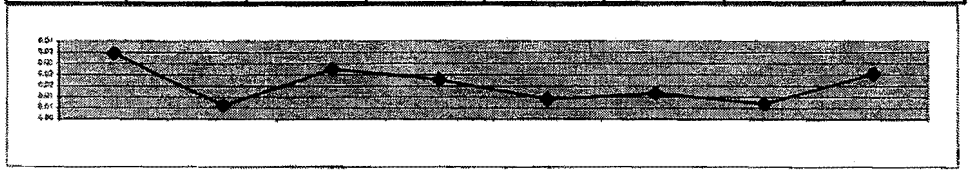
Inpatient Neonate Mortality

		1Q07	2Q07	3Q07	4q07	1Q08	2Q08	3Q08	4Q08
NUM	All neonated who expire at the facility before age 28 days	7	7	7	1	2	1	1	0
DEN	All live-born neonates	304	257	295	71	67	68	24	88
		0.02	0.03	0.02	0.01	0.03	0.01	0.04	0.00



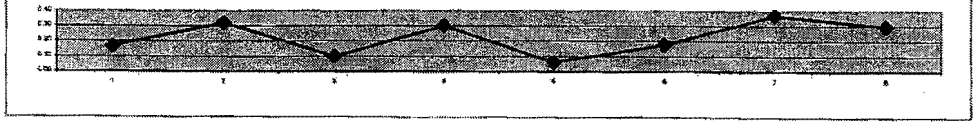
Third and fourth degree perineal laceration

		1Q07	2Q07	3Q07	4q07	1Q08	2Q08	3Q08	4Q08
NUM	All patients with 3rd & 4th degree laceration	5	1	4	3	1	2	1	3
DEN	All patients with vaginal delivery	170	166	178	169	114	175	146	148
		0.03	0.01	0.02	0.02	0.01	0.01	0.01	0.02



VBAC

		1Q07	2Q07	3Q07	4q07	1Q08	2Q08	3Q08	4Q08
NUM	Patients with VBAC	5	8	3	11	1	5	7	5
DEN	Al patient with previous cesarean section	30	25	31	37	17	29	19	17
		0.17	0.32	0.10	0.30	0.06	0.17	0.37	0.29



John H. Stroger Hospital
Quality Assurance Regulatory Affairs Department

Patient Safety
Medication Error Report

1st Quarter 2009 (December 1st 2008 through February 28, 2009)

The **error category** is the severity outcome level resulting from the error. We are categorizing how the error has affected the patient. The levels are from A to I denoting increasing severity. The error category levels are defined as follows:

Category A: Circumstances or events that have the capacity to cause an error

Category B: An error occurred; medication did not reach the patient.

Category C: An error occurred that reached the patient but did not cause patient harm.

Category D: An error occurred that resulted in the need for increased patient monitoring but no patient harm.

Category E: An error occurred that resulted in the need for treatment or intervention and caused temporary patient harm

Category F: An error occurred that resulted in initial or prolonged hospitalization and caused temporary patient harm.

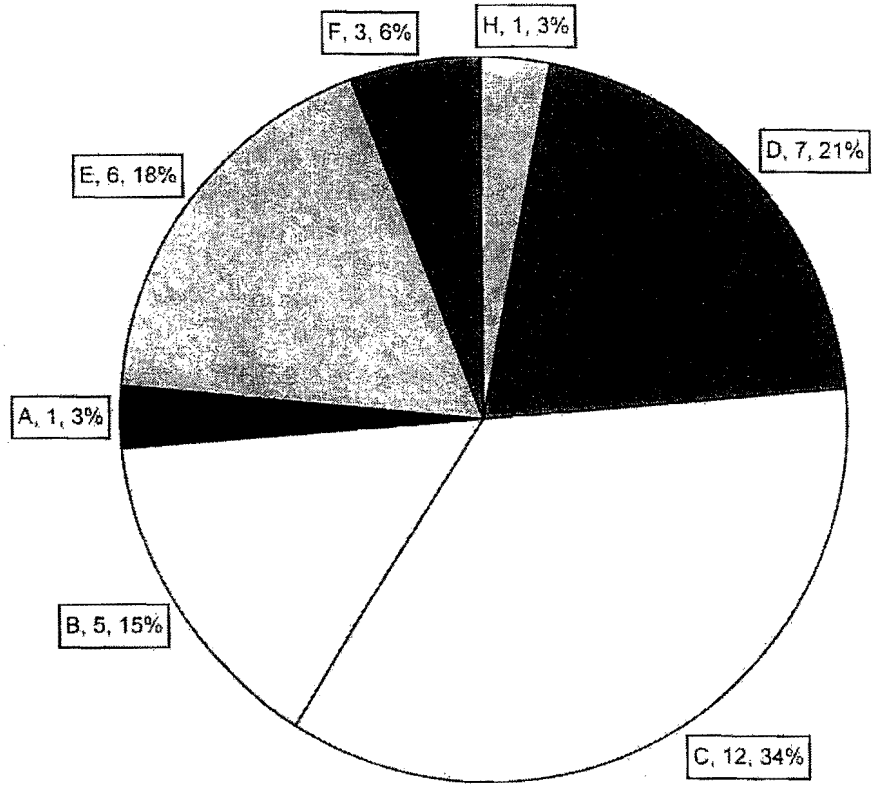
Category G: An error occurred that resulted in permanent patient harm

Category H: An error occurred that resulted in a near-death event (e.g., anaphylaxis, cardiac arrest)

Category I: An error occurred that resulted in patient death

The **Node** tells us where in the **medication process** the initial error occurred. The various node processes are: **Prescribing, Documenting, Dispensing, Administering and Monitoring.**

Stroger Hospital - Patient Safety Committee
MEDMARX Medication Error Report
1st Quarter 2009
12/1/2008 to 2/28/2009 (your facility)



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Elmhurst, IL 60126
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www.giftofhope.org

1st Quarter Donation Activity Report

January - March 2009

John H. Stroger Jr. Hospital of Cook County

Every organ, every tissue, every referral...
is the one that matters. Every time.

Submitted to:

Johnny Brown
Dr. Roxane Roberts
Dr. Kimberly Joseph
Dr. Cohen
Suzanne Klein
Dr. Maurice Lemon
Antoinette Williams
Dr. Richard Keen

Prepared by:
Kathleen Gerrrans
In-House Coordinator
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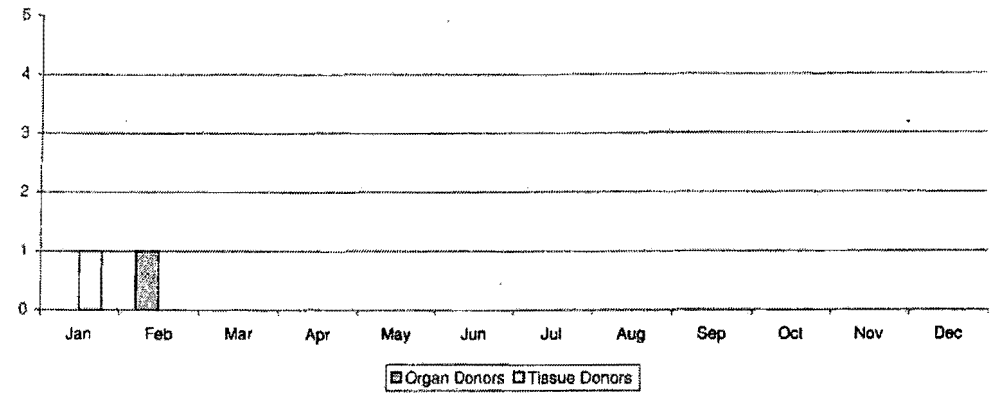
April 24, 2009

1st Quarter 2009 Donation Activity Update

John H. Stroger Jr. Hospital of Cook County

giftofhope



1st Quarter Summary:		YTD	2008 Full Year
All Organ Referrals	6	6	40
Ineligible for Donation	5	5	24
Eligible for Donation	3	3	16
Organ Donors	1	1	9
Consented, Unrealized Donors	0	0	1
No Consent	0	0	6
Vent D/C'd Before Approach	0	0	0
ME/Coroner Denial	0	0	0
Missed Eligible	1	1	4
Total Eligible for Donation	2	2	20
Conversion Rate	**50%**	**50%**	**50%**
Timely Referrals	1	1	16
Untimely Referrals	1	1	4
Timely Notification Rate	**50%**	**50%**	**80%**
Effective Request Process	1	1	14
Ineffective Request Process	0	0	2
Effective Request Rate	**100%**	**100%**	**88%**
Tissue Donors	1	1	10
In-services	2	2	2
# of Hospital Deaths	104	104	417
# of Deaths Called to GOH	96	96	404
Calls to Death Rate	**92%**	**92%**	**97%**

Every organ, every tissue, every referral ... is the one that matters. Every time.

For additional information regarding this report or donation, contact your Gift of Hope representative:

Kathleen Gerrrans
(630) 758-2787
kgerrans@giftofhope.org

Dashboard Key:

Red: Below goal.

Green: Meets/Exceeds Goal.

REFERRALS TO GIFT OF HOPE - 24/7 DONOR HOTLINE 1-800-545-GIFT (4438)

VENTILATED Patients (Organ Referral)

Call Gift of Hope at 1-800-545-GIFT (4438) when your patient exhibits any **ONE** of the following:

- Glasgow Coma Scale (GCS) ≤ 5
  Fixed and dilated pupils
- No response to painful stimuli
- No gag or cough
- No spontaneous respirations

OR prior to discussions with the family regarding:

- Change of code status to DNR
- Discontinuation of life-sustaining therapies

NON-VENTILATED Patients (Tissue Referral)

Call Gift of Hope at 1-800-545-GIFT (4438) as soon as possible after death occurs.

Nurse's role post mortem:

- Provide tissue donation brochure to the family
- Obtain a phone number where the family can be reached within the next two hours
  Administer ocular care - **TLC**

giftofhope℠
Organ & Tissue Donation Network

660 N. Industrial Drive
Elmhurst, IL 60126
630/758-2600
www.giftofhope.org

Definition of Terms

All Organ Referrals Made to Gift of Hope:	All individuals meeting criteria for imminent death that were referred to Gift of Hope.
Ineligible Referrals for Organ Donation:	Individuals deemed unsuitable for organ donation by Gift of Hope.
Eligible Referrals for Organ Donation:	All individuals deemed suitable for organ donation.
Organ Donors:	Individuals for whom consent was obtained and organ(s) recovered for transplant.
Consented, Unrealized Donors:	Individuals for whom consent was obtained, but organ(s) were not recovered.
No Consent:	Eligible referrals for whom consent is denied.
Vent D/C'd Before Approach:	Eligible referrals where the vent was d/c'd before approach.
Medical Examiner/Coroner Denials:	Number of medical examiner/coroner denials of eligible referrals.
Missed Eligible:	All individuals deemed suitable for organ donation who were **not referred** to Gift of Hope.
Conversion Rate:	Organ donors plus consented unrealized donors over eligible referrals plus missed referrals, expressed as a percentage.
Timely Eligible Referrals:	Eligible organ referrals that were referred to Gift of Hope within 2 hours of recognition of clinical triggers.
Untimely Eligible Referrals:	Eligible organ referrals that were **not referred** to Gift of Hope within 2 hours of recognition of clinical triggers.
Rate of Timely Notification:	Timely referrals made to Gift of Hope over total referrals made to Gift of Hope, expressed as a percentage.
Effective Request Process:	Family requests in which Gift of Hope and key hospital staff worked together to determine the most appropriate way to approach a family about donation (regardless of outcome).
Rate of Effective Request Process:	Effective request process over total requests, expressed as a percentage.
Collaborative Conversion Rate Target:	The national collaborative goal is to achieve at 75% (or greater) conversion rate for donation.
Hospital Working Conversion Rate Target:	The hospital working target toward achieving the national collaborative goal.

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John H. Stroger Jr. Hospital of Cook County
Monthly Donation Activity Report

March 2009

Collaborative Conversion Rate Target: 75%
Hospital Working Conversion Rate Target: 65%

NOTE: **Data identified and included after a retrospective medical record review.*

Organ Donation Activity Dashboard

	Trauma		MICU		CCU		SICU		NICU		PICU		Neonatal		Burn		ER		BD Mar Total	DCD Mar Total	BD YTD Total	DCD YTD Total	YTD Total	2008 Full Year
	BD	DCD	BD	DCD	BD	DCD	BD	DCD	BD	DCD	BD	DCD	BD	DCD	BD	DCD	BD	DCD						
All Referrals Made to Gift of Hope:	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	1	2	4	6	40
Of the referrals made, how many were:																								
Ineligible for Donation	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	1	1	4	5	24
Eligible for Donation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	16
Of those eligible for donation, how many were:																								
Organ Donors	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	9
Consented, Unrealized Donors	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
No Consent	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6
Vent D/C'd Before Approach	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical Examiner/Coroner Denial	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Missed Eligible*	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	1	4
Total Eligible for Donation (Eligible + Missed)	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	1	1	2	20
Conversion Rate	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0%	100%	0%	50%	50%
Of the eligible referrals made, how many were:																								
Timely	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	16
Untimely	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Rate of Timely Notification	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	100%	N/A	100%	80%
Of the approaches made, how many were:																								
Effective Request Process	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	14
Ineffective Request Process	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Rate of Effective Request Process	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	100%	N/A	100%	88%
YTD Organ Donor Totals	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	9

Dashboard Key:
Conversion Rate: >75% Green, , <50% Red
Timely Notification Rate: 95-100% Green, , <89% Red
Effective Request Process Rate: 95-100% Green, , <89% Red

Number of Tissue Donors	0	1	10
Number of In-services	0	2	2

67

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John H. Stroger Jr. Hospital of Cook County
Monthly Donation Activity Report

March 2009

Dashboard Details:

In March 2009 two patients were referred to Gift of Hope and both were medically ruled out for donation. There was one missed referral from the Neuro ICU.

Missed Referral:

03/19/09 - 63/M/B - Neuro ICU - This patient was admitted after striking his head on the sidewalk. Upon arrival to the ER on 3/15 he had no response to pain and a GCS of 3. On 3/16 he had a documented loss of pupils, and still no response to pain. His GCS was 3 for the majority of his hospitalization. The MD spoke with the family on 3/16 and told them that he would not survive, and that he recommended withdrawal of care. The family asked for a few days to allow the rest of the family to come and see him before they withdrew care. On 3/19 the patient coded on the vent and expired. Gift of Hope was not called until after the patient expired. He should have been referred to Gift of Hope upon arrival to the Neuro ICU when he had a loss of neurologic function. MR# 1911033

Improvement Opportunities:

To ensure the opportunity of organ and tissue donation for all families the following is recommended:

- Develop and implement a hospital wide Donation-After-Cardiac Death policy to allow all eligible families the opportunity of donation.

  Implement a monthly quality review committee to discuss referrals/donors and ways to improve the process in order to hard wire best donation practices in the units.

- Continue to call in all imminent deaths, especially prior to any terminal extubation, in a timely manner to ensure Gift of Hope has the opportunity to evaluate for organ potential.

- Partner with Gift of Hope in community education (i.e. informational booths) in efforts to increase organ donation awareness among the population served by Stroger.

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Definition of Terms

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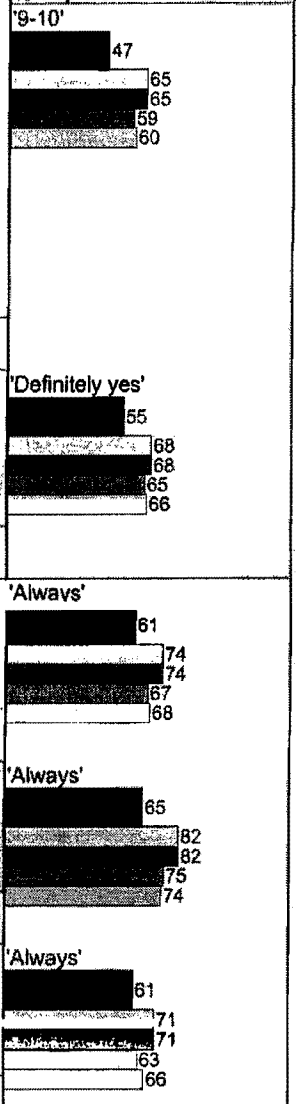
Ineligible Referrals for Organ Donation:	Individuals who are medically ruled-out as unsuitable for organ donation by Gift of Hope
Eligible Referrals for Organ Donation:	All individuals medically suitable for organ donation, whether referred or not referred.
Organ Donors:	Individuals for whom consent was properly obtained and organ(s) recovered with intent to transplant
Consented, Unrealized Donors:	Individuals for whom consent was properly obtained, but organ(s) were not recovered.
No Consent:	Medically suitable individuals for whom consent is denied.
Vent D/C'd Before Approach	Eligible referrals where the vent was d/c'd before approach.
Medical Examiner/Coroner Denials:	Number of medical examiner/coroner denials
Missed Eligible:	All individuals medically suitable for organ donation who were **not referred** to Gift of Hope.
Conversion Rate:	Organ donors plus consented unrealized donors over eligible referrals plus missed referrals, expressed as a percentage
Timely Eligible Referrals:	Eligible organ referrals that were referred to Gift of Hope within 2 hours of recognition of clinical triggers
Untimely Eligible Referrals:	Eligible organ referrals that were **not referred** to Gift of Hope within 2 hours of recognition of clinical triggers.
Rate of Timely Notification:	Timely referrals made to Gift of Hope over referrals made to Gift of Hope, expressed as a percentage.
Effective Request Process:	Family requests in which Gift of Hope and key hospital staff worked together to determine the most appropriate and sensitive way to approach a family about donation (regardless of outcome).
Rate of Effective Request Process:	Effective request process over in-effective request process, expressed as a percentage.
Number of Tissue Donors:	The number of tissue donors.
Number of In-services:	Number of Gift of Hope educational in-service programs.

INPATIENT REPORT

HCAHPS Summary Information

Global DOMAIN Question	n	%	All DB N = 1782	All PG DB N = 1782	SHCC Peer N = 8	SHCC Gov Tea N = 10
Global Rating Item Rate hospital 0-10						
0	2	1%	1%	1%	1%	1%
1	5	2%	0%	0%	1%	1%
2	1	0%	1%	1%	1%	1%
3	7	3%	1%	1%	2%	1%
4	10	4%	1%	1%	2%	2%
5	14	5%	3%	3%	4%	4%
6	13	5%	3%	3%	3%	4%
7	32	12%	7%	7%	10%	8%
8	51	20%	18%	18%	19%	18%
9-10	122	47%	65%	65%	59%	60%
Total	257					
Top Box %ile rank			4	4	1	11
Global Rating Item Recommend this hospital						
Definitely no	7	3%	2%	2%	3%	3%
Probably no	22	8%	3%	3%	5%	5%
Probably yes	87	34%	26%	26%	28%	26%
Definitely yes	143	55%	68%	68%	65%	66%
Total	259					
Top Box %ile rank			10	10	29	11
COMM W/ NURSES						
Never		2%	1%	1%	2%	1%
Sometimes		14%	5%	5%	8%	9%
Usually		23%	20%	20%	24%	22%
Always		61%	74%	74%	67%	68%
Top Box %ile rank			2	2	14	11
Nurses treat with courtesy/respect						
Never	3	1%	0%	0%	1%	1%
Sometimes	32	12%	3%	3%	6%	7%
Usually	57	22%	15%	15%	18%	19%
Always	171	65%	82%	82%	75%	74%
Total	263					
Top Box %ile rank			1	1	1	11
Nurses listen carefully to you						
Never	3	1%	1%	1%	2%	1%
Sometimes	41	16%	5%	5%	8%	9%
Usually	59	23%	24%	24%	27%	24%
Always	159	61%	71%	71%	63%	66%
Total	262					
Top Box %ile rank			7	7	43	22

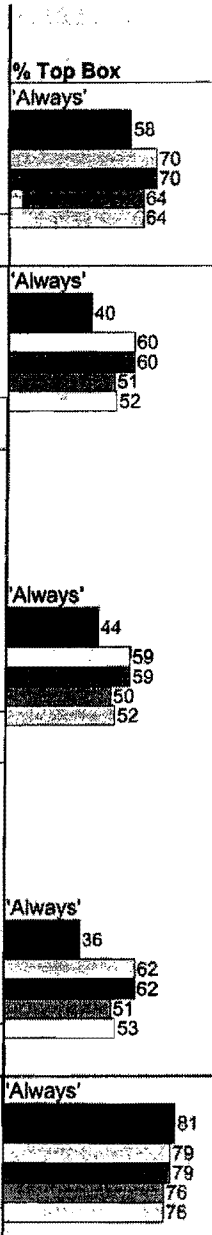


Your Top Box percentage | All PG Database | SHCC Gov. Teaching Custom | All DB | SHCC Custom Peer

INPATIENT REPORT

HCAHPS Summary Information

Global DOMAIN Question	n	%	All DB N = 1782	All PG DB N = 1782	SHCC Peer N = 8	SHCC Gov Tea N = 10
Nurses expl in way you understand						
Never	6	2%	1%	1%	2%	2%
Sometimes	37	14%	5%	5%	8%	10%
Usually	64	25%	23%	23%	26%	24%
Always	150	58%	70%	70%	64%	64%
Total	257					
			Top Box			
			%ile rank	4	4	1	11
RESPONSE OF HOSP STAFF						
Never		12%	3%	3%	6%	6%
Sometimes		24%	9%	9%	14%	15%
Usually		24%	27%	27%	29%	26%
Always		40%	60%	60%	51%	52%
			Top Box			
			%ile rank	1	1	1	11
Screening Item						
Never pressed call button						
Checked	64	24%	13%	13%	14%	19%
Unchecked	200	76%	87%	87%	86%	81%
Total	264					
Call button help soon as wanted it						
Never	14	7%	2%	2%	4%	4%
Sometimes	35	18%	10%	10%	14%	15%
Usually	61	31%	30%	30%	32%	29%
Always	85	44%	59%	59%	50%	52%
Total	195					
			Top Box			
			%ile rank	5	5	14	11
Screening Item						
Need help bathroom/using bedpan						
Yes	71	29%	54%	54%	49%	46%
No	170	71%	46%	46%	51%	54%
Total	241					
Help toileting soon as you wanted						
Never	16	17%	4%	4%	9%	9%
Sometimes	27	29%	10%	10%	14%	15%
Usually	16	17%	24%	24%	25%	23%
Always	33	36%	62%	62%	51%	53%
Total	92					
			Top Box			
			%ile rank	1	1	1	11
COMM W/ DOCTORS						
Never		1%	1%	1%	1%	1%
Sometimes		4%	4%	4%	5%	5%
Usually		14%	16%	16%	18%	17%
Always		81%	79%	79%	76%	76%
			Top Box			
			%ile rank	60	60	86	99



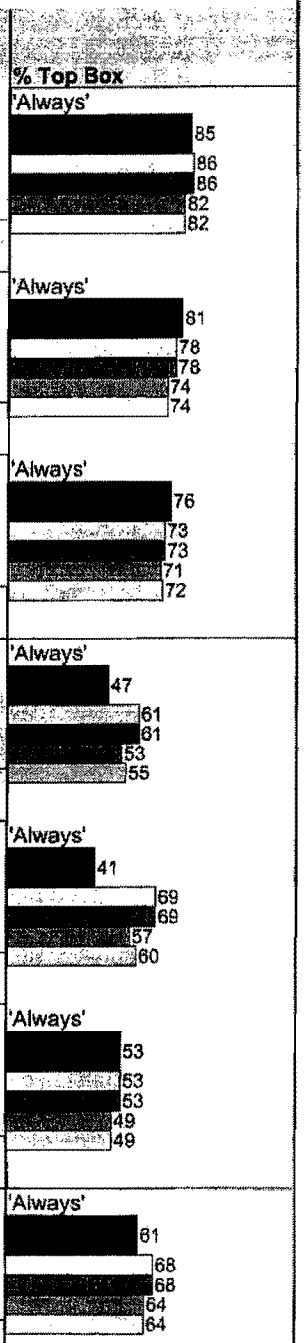
■ Your Top Box percentage ■ All PG Database □ SHCC Gov. Teaching Custom

□ All DB ■ SHCC Custom Peer

INPATIENT REPORT

HCAHPS Summary Information

Global DOMAIN / Question	n	%	All DB N = 1782	All PG DB N = 1782	SHCC Peer N = 8	SHCC Gov Tea N = 10
Doctors treat with courtesy/respect						
Never	2	1%	1%	1%	1%	1%
Sometimes	8	3%	2%	2%	4%	3%
Usually	29	11%	11%	11%	14%	13%
Always	223	85%	86%	86%	82%	82%
Total	262					
Top Box %ile rank			42	42	86	99
Doctors listen carefully to you						
Never	3	1%	1%	1%	1%	2%
Sometimes	14	5%	4%	4%	6%	5%
Usually	33	13%	17%	17%	18%	19%
Always	212	81%	78%	78%	74%	74%
Total	262					
Top Box %ile rank			71	71	99	99
Doctors expl in way you understand						
Never	2	1%	1%	1%	1%	2%
Sometimes	13	5%	5%	5%	6%	6%
Usually	49	19%	20%	20%	21%	20%
Always	198	76%	73%	73%	71%	72%
Total	262					
Top Box %ile rank			62	62	86	89
HOSPITAL ENVIRONMENT						
Never		10%	3%	3%	5%	5%
Sometimes		17%	9%	9%	14%	14%
Usually		26%	27%	27%	28%	27%
Always		47%	61%	61%	53%	55%
Top Box %ile rank			3	3	1	1
Room and bathroom kept clean						
Never	31	12%	2%	2%	5%	4%
Sometimes	56	22%	7%	7%	13%	13%
Usually	65	25%	21%	21%	25%	23%
Always	106	41%	69%	69%	57%	60%
Total	258					
Top Box %ile rank			1	1	1	1
Area around room quiet at night						
Never	20	8%	3%	3%	6%	6%
Sometimes	33	13%	10%	10%	14%	14%
Usually	70	27%	33%	33%	31%	31%
Always	137	53%	53%	53%	49%	49%
Total	260					
Top Box %ile rank			50	50	86	62
PAIN						
Never		3%	1%	1%	2%	2%
Sometimes		11%	6%	6%	9%	9%
Usually		25%	24%	24%	25%	24%
Always		61%	68%	68%	64%	64%
Top Box %ile rank			11	11	14	22



■ Your Top Box percentage ■ All PG Database □ SHCC Gov. Teaching Custom

□ All DB ■ SHCC Custom Peer

05/01/2009 15:48:27 EST

PRESS GANEY

All data including past trended data are benchmarked against the period ending 03/31/2009

For a list of filter and benchmark definitions, click here.

1-800-232-8032

INPATIENT REPORT

HCAHPS Summary Information

Global DOMAIN Question	n	%	All DB N = 1782	All PG DB N = 1782	SHCC Peer N = 8	SHCC Gov Tea N = 10	% Top Box
Screening Item							
Need medicine for pain							
Yes	183	73%	71%	71%	79%	73%	
No	67	27%	29%	29%	21%	27%	
Total	250						
Pain well controlled							'Always'
Never	7	3%	1%	1%	2%	2%	57
Sometimes	25	12%	7%	7%	10%	10%	61
Usually	57	28%	30%	30%	31%	29%	61
Always	118	57%	61%	61%	57%	59%	57
Total	207						59
			Top Box				
			%ile rank	25	25	43	33
Staff do everything help with pain							'Always'
Never	5	2%	1%	1%	2%	2%	65
Sometimes	21	10%	5%	5%	8%	8%	75
Usually	45	22%	18%	18%	20%	20%	75
Always	133	65%	75%	75%	71%	70%	71
Total	204						70
			Top Box				
			%ile rank	5	5	1	22
COMM RE MED							'Always'
Never		17%	13%	13%	14%	14%	53
Sometimes		12%	10%	10%	12%	11%	58
Usually		18%	19%	19%	18%	18%	58
Always		53%	58%	58%	56%	57%	56
							57
			Top Box				
			%ile rank	20	20	14	11
Screening Item							
Given medicine had not taken before							
Yes	157	63%	61%	61%	64%	63%	
No	92	37%	39%	39%	36%	37%	
Total	249						
Tell you what new medicine was for							'Always'
Never	10	6%	4%	4%	4%	5%	67
Sometimes	20	11%	8%	8%	11%	10%	71
Usually	29	16%	17%	17%	17%	17%	71
Always	121	67%	71%	71%	68%	69%	68
Total	180						69
			Top Box				
			%ile rank	26	26	43	33
Staff describe medicine side effect							'Always'
Never	52	29%	21%	21%	24%	23%	38
Sometimes	23	13%	12%	12%	12%	13%	45
Usually	34	19%	21%	21%	19%	19%	45
Always	68	38%	45%	45%	44%	45%	44
Total	177						45
			Top Box				
			%ile rank	17	17	14	1

Your Top Box percentage | All PG Database | SHCC Gov. Teaching Custom

All DB | SHCC Custom Peer

INPATIENT REPORT

HCAHPS Summary Information

Global DOMAIN Question	n	%	All DB N = 1782	All PG DB N = 1782	SHCC Peer N = 8	SHCC Gov Tea N = 10	% Top Box
DISCHARGE							'Yes'
No		26%	20%	20%	19%	22%	74
Yes		74%	80%	80%	81%	78%	80
							80
							81
							78
			Top Box				
			%ile rank	14	14	1	22
Screening Item							
Left hospital- destination							
Own home	212	83%	84%	84%	78%	84%	
Another home	33	13%	5%	5%	12%	9%	
Another facility	11	4%	11%	11%	10%	7%	
Total	256						
Staff talk about help when you left							'Yes'
No	65	28%	22%	22%	21%	24%	72
Yes	171	72%	78%	78%	79%	76%	78
Total	236						78
							79
							76
			Top Box				
			%ile rank	18	18	14	28
Info re symptoms/prob to look for							'Yes'
No	59	25%	18%	18%	16%	19%	75
Yes	180	75%	82%	82%	84%	81%	82
Total	239						82
							84
							81
			Top Box				
			%ile rank	15	15	1	11
About You Item							
Rate overall health							
Excellent	22	8%	12%	12%	11%	14%	
Very Good	36	14%	26%	26%	24%	26%	
Good	102	39%	32%	32%	35%	30%	
Fair	80	31%	22%	22%	24%	22%	
Poor	19	7%	8%	8%	7%	7%	
Total	259						
About You Item							
Highest grade or school completed							
<= 8th grade	38	15%	7%	7%	8%	12%	
Some high school	44	18%	11%	11%	13%	14%	
High school grad	74	29%	34%	34%	33%	28%	
Some college	66	26%	27%	27%	28%	26%	
4-yr coll. grad.	19	8%	11%	11%	9%	9%	
4+ yrs college	10	4%	11%	11%	10%	10%	
Total	251						

Your Top Box percentage | All PG Database | SHCC Gov. Teaching Custom

All DB | SHCC Custom Peer

05/01/2009 15:48:27 EST

All data including past trended data are benchmarked against the period ending 03/31/2009

For a list of filler and benchmark definitions, click here.

PRESS GANEY

1-800-232-8032

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INPATIENT REPORT

HCAHPS Summary Information

Global DOMAIN Question	n	%	All DB N = 1782	All PG DB N = 1782	SHCC Peer N = 8	SHCC Gov Tea N = 10	% Top Box
About You Item Spanish,Hispanic or Latino							
Yes	0	0%	0%	0%	N<7	N<7	
No	0	0%	0%	0%	N<7	N<7	
Not Span/Hisp/La	163	71%	93%	93%	85%	75%	
Puerto Rican	9	4%	1%	1%	2%	1%	
Mex,Mex Amer,Chi	41	18%	3%	3%	7%	14%	
Cuban	0	0%	0%	0%	1%	0%	
Other	16	7%	3%	3%	5%	9%	
Total	229						
About You Item Race-White							
Yes	74	28%	85%	85%	67%	60%	
No	190	72%	15%	15%	33%	40%	
Total	264						
About You Item Race-Black or African American							
Yes	125	47%	7%	7%	21%	21%	
No	139	53%	93%	93%	79%	79%	
Total	264						
About You Item Race-Asian							
Yes	24	9%	2%	2%	3%	4%	
No	240	91%	98%	98%	97%	96%	
Total	264						
About You Item Race-Hawaiian or Pacific Islander							
Yes	1	0%	0%	0%	1%	1%	
No	263	100%	100%	100%	99%	99%	
Total	264						
About You Item Race-Ameri Indian Alaska Native							
Yes	4	2%	2%	2%	2%	2%	
No	260	98%	98%	98%	98%	98%	
Total	264						
About You Item Language mainly speak at home							
English	179	75%	96%	96%	88%	80%	
Spanish	41	17%	3%	3%	9%	17%	
Other	20	8%	1%	1%	3%	3%	
Total	240						

■ Your Top Box percentage ■ All PG Database ☐ SHCC Gov. Teaching Custom

☐ All DB ■ SHCC Custom Peer

NATIONAL PATIENT SAFETY GOALS – 2009 Update

	GOAL	JHS Status (06/05/2009)
Goal 1 NPSG.01	**Improve the accuracy of patient identification.**	
NPSG.01.01.01 NPSG.01.03.01	*Use at least two patient identifiers when providing care, treatment or services. For meds, blood products, blood sample and specimen collection, providing treatment or procedures. -includes requirements for labeling blood and other specimens in the presence of the patient.*	Policy in place since 2006. Reviewed and revised for 2009. Hospital-wide monitoring via incident reporting with remedial education and other action taken as needed. Nursing conducts monitoring, including for transfusions as a departmental QA indicator. Compliance for blood product administration is currently at 99%. Compliance for other care varies from 80-100% by nursing division.
Goal 2 NPSG.02	**Improve the effectiveness of communication among caregivers.**	
NPSG.02.01.01	*For verbal or telephone orders or for telephonic reporting of critical test results and critical results of routine tests, verify the complete order or test result by having the person receiving the information record and "read-back" the complete order or test result.*	Procedures in place since 2006, Reviewed for 2009 policy revisions. Included in Patient Safety Rounds and staff education.
NPSG.02.02.01	*Standardize a list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization, the **"DO NOT USE"** list. . . .*	Implemented in 2005, updated annually through 2009. Monitored in some areas where problems were identified in the past and included in Patient Safety Rounds and staff education.
NPSG.02.03.01	*Measure, assess and, if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values, including critical results for routine labs/tests.*	Updated in 2007 for Labs and Radiology critical tests and result reporting. 2008 and 2009 review and revisions done. Monitored by Labs and Radiology and reported to HWQAIC monthly. Most recent monitoring report showed Lab critical results were reported inpatient directly to a physician 96% of the time and within the 60 minute time limit 96.9% of the time. Outpatient, the results were reported directly to a physician 94.1% of the time and within the 60 minute limit 97.6% of the time. For Radiology the results were reported to an identified physician

	Goal	JHS Status (06/05/2009)
NPSG .02.05.01	*Implement a standardized approach to "hand off" communications, including an opportunity to ask and respond to questions. Must include up-to-date information on care, treatment, services, condition, changes or anticipated changes; process for verification of received information (repeat-backs, read-backs, etc); opportunity to review relevant historical data; opportunity to ask questions, minimization of interruptions during the hand-off.*	-SBAR was implemented by nursing in 2006-2007 but not widely done. It has been incorporated into NPSG 16, to structure communication for rapid responses. -In 2008 Nursing, QA, and Perioperative Services developed and implemented a PI project through a RWJ/ JCAHO grant as a beta test site. Nursing-wide web based education on communication skills was taken by more than 800 nursing staff as an introduction to the need for change. Performance improvement activities included the use of checklist for handoff between 4 nursing areas (Pre-op - Intra-op, Post-Op, & Receiving Unit) and implementation of alpha-numeric pager protocol for notifying unit nursing staff of impending surgical admissions. Monitoring data is presented at the OR Committee monthly. Developers of the web-based educational program have proposed continuing the project and expanding content in 2009 to include physicians and physician - nursing handoff communication skills. This will require reconvening the committee.
Goal 3 NPSG.03	**Improve the safety of using medications.**	
NPSG .03.03.01	*Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used by the organization, and take action to prevent errors involving the interchange of these drugs.*	Compliant since goal first implemented. Using Tall-man lettering in pharmacy system for orders and dispensing. The LASA list is posted on the intranet and the policy is in place. Annual review done for 2009. Monitoring for problems is ongoing via reported problems.
NPSG .03.04.01	1. *Label all medications, medication, or other solutions on and off the sterile field.* 2. *Labeling must occurs when transferred from original packaging.* 3. *Must include drug name, strength, exp. date, time if less than 24 hrs.* 4. *Must be verified verbally and visually by two qualified individuals if the person preparing the medication is not administering it.* 5. *Only one medication/solution to be labeled at one time.* 6. *Unlabeled meds or solutions immediately discarded.* 7. *All original containers remain for reference in the area until the end of the procedure.* 8. *All labeled containers are discarded at the end of the procedure.* 9. *At shift change or relief- all meds/solutions on and off sterile field reviewed.*	Procedures were implemented in 2006 when goal first implemented. Educational information is posted for OR staff. A new policy for 2009 was done. Monitoring needed in the OR and other procedure areas in the hospital.

	GOAL	JHS Status (06/05/2009)
NPSG.03.05.01	***Reduce the likelihood of patient harm associated with the use of anticoagulation therapy.*** To be fully implemented by January 1, 2009.	Bureau-wide team established in October 2007. Draft guidelines created, by March 2008. Guidelines circulated for discussion, revised and recirculated. Stroger guidelines' trial completed in October 2008 and additional revisions done by January 2009. Stroger guidelines approved by EMS. Cerner tab created. And guidelines posted in January 2009. Special training sessions were done for physician and nursing staff from January 2009 through May 2009. Anticoagulation policy created,reviewed and revised January – May/2009. Pediatric guidelines for some medications were finalized in May 2009 and posted to the anticoagulation website/tab in June.
Goal 7 NPSG.07	**Reduce the risk of health care-associated infections.**	
NPSG.07.01.01	*Comply with current Centers for Disease Control and Prevention (CDC) or World Health Organization hand hygiene guidelines.*	Implemented and monitored. Major work done since 2007 including adding annual training requirement. Ongoing monitoring by Inf. Control and nursing shows that compliance is still problematic. Nursing will be moving to use of progressive discipline in 2009. This is a QA indicator for the Dept of Nursing. Needs continued f/u and monitoring.
NPSG0.7.02.01	*Manage as sentinel events, including conducting a root cause analysis, of all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.*	Infection Control receives data and reports to Inf. Control Committee and to the HOSC which oversees the root cause analysis process. Need further review of how we are capturing these events.
NPSG0.7.03.01	*Implement evidence-based practices and guidelines to prevent health-care associate infections due to multidrug-resistant organisms.* <u>*Required Timeline:*</u> *April 1, 2009: responsibility assigned.* *July 1, 2009: work plan in place* *October 1, 2009: pilot testing in at least one clinical unit.* *January 1, 2010: Full implementation.*	April 1, 2009: Responsibility assigned to a work group.

	GOAL	JHS Status (06/05/2009)
NPSG0.7.04.01	*Implement evidence-based practices and guidelines to prevent central line-associated bloodstream infections.* *Required Timeline:* *April 1, 2009: responsibility assigned.* *July 1, 2009: work plan in place* *October 1, 2009: pilot testing in at least one clinical unit.* *January 1, 2010: Full implementation*	April 1, 2009: Responsibility assigned to a work group.
NPSG0.7.05.01	*Implement best practices for preventing surgical site infections.* *Required Timeline:* *April 1, 2009: responsibility assigned.* *July 1, 2009: work plan in place* *October 1, 2009: pilot testing in at least one clinical unit.* *January 1, 2010: Full implementation*	April 1, 2009: Responsibility assigned to a work group.
Goal 8 NPSG08	**Accurately and completely reconcile medications across the continuum of care.**	**NOTE: The Joint Commission is not scoring any of NPSG08 during surveys in 2009- indicates possible changes in requirement for 2010.**
NPSG0.8.01.01	*When patient enters the hospital or is admitted, complete list of meds taken at home (dose, route, frequency) is created and documented. Meds ordered for the patient while under care of hospital are compared to the list created at the time of entry to the hospital or admission.*	In 2007 major revision of procedures, policies created and staff education and monitoring done. 2008 monitoring less frequent; improvement occurred but problems exist. 2009: Nursing is monitoring medication reconciliation with the latest results showing compliance by nursing divisions ranges from 75-95%
NPSG.08.02.01	*A complete & reconciled list of the medications is communicated to the next provider of service and the communication is documented When pt. is discharged home, the list is provided to the known primary care provider, or original referring provider or next provider. When unknown or no provider, giving the list goes to the patient/family is sufficient. Documentation of communication is required.*	In 2007 major revision of procedures, policies created and staff education and monitoring done. 2008 monitoring less frequent; improvement occurred but problems exist. 2009: Need monitoring.
NPSG.08.03.01	*When a patient leaves the organization's care, a complete, reconciled med list is provided directly to the pt. & as needed the family and explained.*	In 2007 major revision of procedures, policies created and staff education and monitoring done. 2008 monitoring less frequent. Improvements were made by including reconciled medication list on the discharge papers given to patients. 2009: Need monitoring

	GOAL	JHS Status (06/05/2009)
NPSG.08.04.01	*In settings where medications are used minimally, or for short duration, the hospital obtains and documents accurate list of the patient's current medications and known allergies. If only short-term meds are prescribed and no changes made to the current meds, the patient/family are provided with the list of the short-term meds to be continued after leaving the hospital. Documented complete med reconciliation is only required if new long-term meds are prescribed, or changed, or the patient is going to be admitted to the inpatient setting.*	Applies to ED; office based surgery; outpt. radiology; some ambulatory areas. We are currently compliant and doing more than this requires in some areas, (e.g. Emergency Dept.).
Goal 9 NPSG.09	**Reduce the risk of patient harm resulting from falls.**	
NPSG.09.02.01	*Implement a fall reduction program, educate staff and the patients/family and evaluate the effectiveness of the program.*	Procedures, documentation and monitoring changed in 2007. Nursing Dept. monitoring and reports go to Pt. Safety Committee and to HWQAIC. Compliant with requirement to have a program and to evaluate it. Nursing data shows some problems in completing and documenting assessments and interventions. Documentation in Cerner will be added in June 2009. The rate of falls in the hospital (2.5-3.5/1000 patient days) is well below the national benchmark (4.3/1000 pt. days). This is a QA indicator for the Dept of Nursing.
Goal 13 NPSG13	**Encourage patients' active involvement in their own care as a patient safety strategy.**	
NPSG.13.01.01	*Identify the ways in which the patient and his or her family can report concerns about safety and encourage them to do so. This includes information on reporting concerns, information on infection control for hand hygiene, respiratory hygiene and contact precautions and, for surgical patients, information on measures taken to prevent adverse events in surgery.*	We have numbers and information for reporting concerns to the Hospital Administration in the Pt. Handbook and on posters. We have policy, reviewed and revised for 2009. Perioperative Services is implementing education for surgical patients. A new patient handbook and new posters for inpatient rooms are in progress.

	GOAL	JHS Status (06/05/2009)
Goal 15 NPSG.15	**The organization identifies safety risks inherent in its patient population.**	
NPSG.15.01.01	*The organization identifies patients at risk for suicide. [Applicable only to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.]*	Have required elements, and more, in place. Major work done during 2008-2009. Staff education done. Resources, including hotline numbers for pts/family, and assessment tools for providers are on the hospital intranet and can be printed out. The Dept. of Psychiatry conducts follows the issue.
Goal 16 NPSG.16	***Improve recognition and response to changes in a patient's condition.***	
NPSG.16.01.01	*Select a suitable method that enables health care staff to directly request additional assistance from a specially trained individual(s) when the patient's condition appears to be worsening. Develop criteria and education. Encourage patient and family to seek assistance. Measure arrests and mortality rates before and after and evaluate the program.*	Code team and pre-arrest calling of codes was already in place. The Resuscitation Subcommittee of the Critical Care Committee has developed physiological criteria, policies and a mechanism for staff, patient or families to activate a "Code Help" response. The proposal was reviewed and revised by physician and nurse leadership. Staff and patient education materials are also developed. Full implementation of the new program will take place in July.
Universal Protocol UP	*Preoperative, intraoperative procedures to ensure right pt., right procedure and that all equipment, supplies known to be needed are present prior to the procedure being done. Includes the requirement for a "Time-Out" prior to starting procedure. Completed components of the UP and time-out must be documented.*	Policies and procedures implemented when goal was initiated. 2007 reviewed and revised and educated staff. 2008 monitoring done in the OR and reported to the OR Committee. 2009: Policy and procedure reviewed and revised. It is necessary to add a mechanism for temporarily documenting verifications done in pre-procedure areas (white boards, paper check lists). Staff education and monitoring needs to be done in all areas, especially critical care areas and procedure areas outside the OR.
UP.01.01.01	*Conduct a preprocedure verification process*	See above
UP.01.02.01	*Mark the procedure site*	See above
UP.01.03.01	*A time-out is performed immediately prior to starting procedures.*	See above

V.Cervantes
06/09/2009

Cook County Health and Hospitals System

Meeting of the Quality and Patient Safety Committee

June 17, 2009

ATTACHMENT #2

Report to the CCHHS Quality and Patient Safety Committee
Meeting of June 17, 2009

RE: Smoke-free Campus Committee Update

*A committee with representation from the System Affiliates has been formed to chart and oversee the plan to implement a smoke-free policy for all of the System's campuses.

*Committee members:

Robert Cohen, MD
David Goldberg, MD
Clifton Clarke, MD
Homer Abiad, MD
Srinivas Joelpalem, MD
Cecil Marchand
Paris Partee
Teawana Cole-Chambers
Brenda Averhart
Chief Charles Booth
Marcel Bright
Jack Raba, MD
David Small

*Information gathering in process including review of "best practices" in the adoption by healthcare institutions of smoke-free environments, and discussion with representatives of Rush where that organization accomplished this process in recent past.

*In process of developing initial signage and message posting to alert the public and staff of intent to implement smoke-free environments for all campuses operated by the CCHHS.

*Implementation plan to be drafted by June 30th and will be shared with the Quality and Patient Safety Committee at the July meeting.

Cook County Health and Hospitals System

Meeting of the Quality and Patient Safety Committee

June 17, 2009

ATTACHMENT #3

LABORATORY STATUS REPORT CMS June 2009

Laboratory CMS Status Update

Documentation Equipment Maintenance:

- ☐ Continue to perform quality audits twice monthly to provide oversight of equipment maintenance and quality control.

Post analytic Systems QA:

- ☐ Medical Director conducts a daily quality meeting to review and resolve unusual occurrences.

Laboratory CMS Status Update

Proficiency Testing

- Medical Director performs monthly reviews of each laboratory sections' 2009 proficiency test reports and documentation to ensure compliance and test proficiency.

Competency Assessment Program

- Currently 71% of the 2009 competency staff assessment if completed.

Laboratory CMS Status Update

Critical Values

- Daily oversight process implemented to ensure all critical values are reported timely. April & May All critical values were called.

Policies/Procedures

- Currently 33% or 335 laboratory procedures are posted on the intranet.

Laboratory CMS Status Update

Laboratory QA Indicator Performance Report

- Report card on laboratory performance measures are presented monthly to Hospital Quality Meeting.